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ABSTRACT

This document outlines Oregon's standards for services provided to students with speech or language impairments, focusing on eligibility requirements, service providers, referral and evaluation procedures, multidisciplinary team function, individual education program content, and delivery of services. It also discusses program management, including program evaluation and community involvement, and outlines requirements for facilities and materials. The appendices contain: test review forms, a list of evaluation instruments for speech and language, excerpts from the "Joint Technical Standards for Educational and Psychological Testing," a normal distribution curve, severity rating scales from four school districts, guidelines for caseload size, and guidelines for the employment of supportive personnel. (JDD)

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Guidelines for Speech-Language Services in Oregon

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A Technical Assistance Paper Developed by
Oregon Speech and Hearing Association
and
Oregon Department of Education

1989

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Foreword

The Department of Education is pleased to share this document with the citizens of Oregon. While it focuses on a specific area addressed by educators — speech and language disabilities — it is written for educators, administrators, parents, program planners, educational support staff, community agencies and speech-language professionals. We know this information will foster understanding and appropriate use of these services.

We commend the efforts of many professionals in preparing this document. It was truly a joint project by the state, professional organizations and community. The Oregon Speech and Hearing Association saw the need and gave full support to the project. The persistence of the committee to maintain a focus on the needs of all Oregon, understanding the diversity of our state, is noteworthy.

For further information, contact Maurine Otos, Coordinator for Regional Services, 378-3136.

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Acknowledgments

This technical assistance paper is the product of the committee members (listed on page i) who received direction and support from the Oregon Speech and Hearing Association, the Oregon Department of Education and many additional Oregonians in its development.

The assistance of school district administrators, who contributed staff time to the project, is appreciated, as is that of the Oregon Speech and Hearing Association Executive Board, who provided ongoing support. Vonnie Haley-Condon, past president of the Oregon Speech and Hearing Association, and Pat Ellis of the Oregon Department of Education, were instrumental in the paper's initiation and development. State Department of Education documents from Arkansas, Florida, Iowa, Kansas, Nebraska, New Jersey, North Carolina and South Carolina were valuable for review and study.

The efforts of educators, parents and allied professionals who reviewed the drafts were also most helpful in developing a readable document. In addition, speech-language pathologists throughout Oregon provided material for the text, and reviewed and critiqued each draft. The final product reflects their care and expectations for a useful description of their professional responsibility in our state.

Many topics and issues were reviewed for inclusion. The final topics covered here are those the committee felt provide the information needed by school districts, parents, regular and special educators, and speech-language pathologists to understand the services to communicative disabled students in Oregon.

This document does not include all the information relied on by speech-language pathologists to provide service. Many other resources are available for the professional. Readers, who have questions regarding either the contents or subject matter beyond that covered, are directed to contact a speech-language pathologist in their school district or community for further information.

Writing documents of this nature is a demanding and challenging task. The committee is grateful for the patient support received throughout the process. Thank you.

I

Introduction

Services to students with speech or language impairments are an integral part of every school's program. The passage of Public Law 94-142, with its mandate for a free and appropriate education for all handicapped students has brought about the need for statewide guidelines to assure equitable and standardized services to students with speech or language impairments.

The American Speech-Language-Hearing Association (ASHA) has stated "...standards and guidelines for school language speech and hearing programs must be written to accommodate differing patterns of school district administration, supervision, and special program management. Since school districts differ in size and population served (for example, rural, urban, suburban, socioeconomic status, racial and ethnical variations), a variety of program models is required to accommodate the diverse needs of pupils in developing communication skills."[1]

This document will:

1. Outline **STANDARDS** for eligibility requirements, referral and evaluation procedures, multidisciplinary team function, individual education program content and delivery of services for students with speech or language impairments.

2. Provide **GUIDELINES** for consistent services throughout the State of Oregon for speech-language pathologists, teachers, administrators, parents and other professionals.

3. Serve as a **REFERENCE** for the evaluation of a school district's speech-language program.

This paper was written by Oregon public school speech-language pathologists representing all regions and district sizes. This work reflects a commitment to standards and is intended to be a basis for the implementation of federal and state laws, not a comprehensive regulatory document.

[1] *Standards and Guidelines for Comprehensive Language, Speech and Hearing Programs in the Schools*, American Speech-Language-Hearing Association, Washington, DC (1973-74)

II

Eligibility Requirements and Service Providers

Eligibility

In Oregon, special education services are available for preschool and school age children with speech-language impairment. Students are determined eligible for special services based on established Oregon state eligibility criteria. No student in Oregon shall be determined eligible for speech-language services without the evaluation of a speech-language pathologist. Regulations for determining eligibility for speech-language impaired students in Oregon are found in current Oregon Administrative Rule 581-15-051(3), approved February 1986. The rule reads as follows:

a. Eligibility as a student with a communicative disorder shall be determined by a multidisciplinary team. The team shall include two or more individuals, at least one of whom shall be a specialist knowledgeable and experienced in the education of students with the suspected disability.

b. The following are required:

   (A) A speech and language assessment administered by a certificated or licensed speech and language pathologist;

   (B) A physician's statement by an otolaryngolotist or other physician licensed by a State Board of Medical Examiners when the student has a suspected voice disorder or when a medical diagnosis is needed; and

   (C) A hearing screening.

c. Other information related to the student's suspected disability shall be obtained when the minimum requirements do not adequately assess the problem.

d. The multidisciplinary team may determine that a student has an ARTICULATION disorder when:

   (A) The student, given a test of articulation competence following developmental norms, exhibits disordered misarticulations of one or more phonemes; and

   (B) The articulation disorder interferes with communication, and calls attention to itself.

e. The multidisciplinary team may determine that a student has a VOICE disorder when the student demonstrates chronic vocal characteristics that deviate in at least one of the areas of pitch, quality, intensity and/or resonance.

f. The multidisciplinary team may determine that a student has a FLUENCY problem when:

   (A) The student demonstrates an interruption in the rhythm and/or rate of speech, which is characterized by hesitations, repetitions, and/or prolongations of sounds, syllables, words or phrases; and

   (B) The disorder interferes with communication and calls attention to itself.

g. The multidisciplinary team may determine that a student has a LANGUAGE disorder when the student demonstrates a significant delay in one or more of the following areas: phonology, morphology, syntax, semantics or pragmatics as indicated by standard tests and/or language samples such as to interfere with the student's educational progress.

h. The multidisciplinary team shall prepare a statement of eligibility and each member of the team shall sign the statement signifying his/her concurrence or dissent.

Oregon law provides eligibility criteria for visually impaired, hearing impaired, orthopedically impaired, specific learning disabled, seriously emotionally disturbed, mentally retarded, autistic, deaf/blind and other health impaired. A speech-language pathologist knowledgeable and experienced with the suspected disability must provide all required communication assessments.

Students suspected of being autistic are required to be evaluated by a speech-language pathologist to determine functional communication.

In Oregon, special education services are available for preschool children and are regulated by the Early Intervention Law (OAR 309-41-200 through OAR 309-41-255).

To determine eligibility there must be documentation that:

The referred child has a vision impairment, hearing impairment, mental retardation, or a developmental disability and the child's developmental age is:

1. Fifty-five to seventy-five percent of the child's chronological age in three or more of the following areas:

    a. Gross motor
    b. Fine motor
    c. Expressive language
    d. Receptive language
    e. Cognitive
    f. Self-help; and
    g. Capacity to relate appropriately to people, objects, or events; or

2. Forty to fifty-five percent of the child's chronological age in two of the skill areas in Subsection 3 (b) (1) of this rule; or

3. Less than forty percent of the child's chronological age in one of the skill areas in Subsection 3 (b) (1) of this rule; or

4. In the case of children below 18 months of age, there is medical documentation that the child has an identified genetic, neurological, muscular, or medical condition that will result in the child being developmentally disabled.

Service Providers

Oregon law requires individuals who practice speech-language pathology to be certificated and/or licensed. The Basic or Standard Speech Impaired Teaching Certification is required for employment in public schools. This certification process is regulated by the Teacher Standards and Practices Commission (OAR 584-38-320 for Basic and 584-40-290 for Standard). Local educational agencies may contract for the services of a licensed speech-language pathologist.

Licensure is required for speech-language pathologists providing services in the private sector and is regulated by the Oregon State Board of Examiners in Speech Pathology and Audiology (ORS 681.250).

Speech-language pathologists plan, direct, and participate in programs for students who are speech-language impaired. They seek to prevent language, speech and hearing disorders and work to improve methods for evaluation and treatment of children with speech or language impairments. Speech-language pathologists also engage in activities to increase public understanding and knowledge of communication problems.

III

Multidisciplinary Approach

Throughout the individualized education program process a multidisciplinary approach is necessary for comprehensive management. A multidisciplinary team is a group of individuals who share information regarding a student's needs. The composition of a team will be determined by its purpose and the complexity of a student's problems.

A multidisciplinary team has varied responsibilities in providing for the education of students with speech or language impairments. A multidisciplinary approach is used for all processes listed in Figure 1. Processes which require a multidisciplinary team are specified by federal law and require inclusion of the parent, teacher and district representative. The speech-language pathologist may function as the teacher in conjunction with the parent and a district representative, or the speech-language pathologist may function as the district representative with the parent and the teacher.

Additional members may include, but not be limited to, the guidance counselor, psychologist, audiologist, nurse, social worker, building administrator, learning disabilities specialist, occupational therapist, physical therapist, teacher of the visually impaired, mobility specialist, teacher of the hearing impaired, teacher of the severely handicapped, and teaching assistants.

PROCESSES USING MULTIDISCIPLINARY APPROACH

Process	Responsibility	District Rep.	Teacher	Parent	Speech-Language Pathologist	One other service provider	Other interested parties
Referral	determines need for evaluation				+	+	0
Evaluation	• assessment • determining present level of functioning				☆	+	0
Eligibility	• determination of eligibility for speech-language services • presentation of evaluation results				☆	☆	0
Individual Education Program (IEP)	develop plan for service	☆	☆	☆	①		0
Placement/Services	determines least restrictive environment, service providers, etc.	☆	☆	☆	①		0
Annual Review	assess program revises Individual Education Program (IEP) as needed	☆	☆	☆	①		0
Three Year Re-evaluation	determines eligibility	☆	☆	☆	①		0

Code:

☆ = Required

\+ = Recommended

0 = Optional

① = The speech-language pathologist may function as teacher in conjunction with parent and district representative (or) the speech-language pathologist may function as district representative in conjunction with parent and teacher representative.

FIGURE 1

IV

Implementation of Oregon Administrative Rules

All state and federal requirements for education of the handicapped apply to students with speech or language impairments. The process begins with referral/identification and is followed by diagnostic evaluation, determination of eligibility, development of the individual education program (IEP), appropriate placement, and the annual review and revision of the student's program. The flow chart in Figure 2 illustrates this process.

FLOW CHART FOR SPEECH/LANGUAGE SERVICES

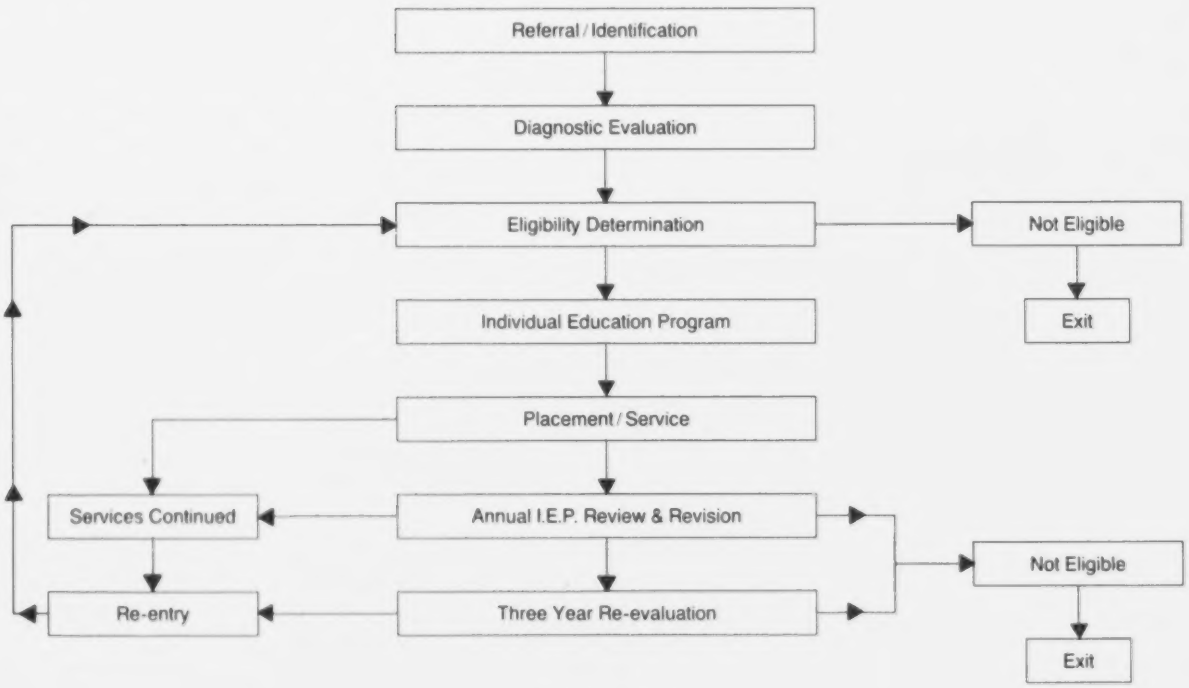

FIGURE 2

All steps in the flow of services must be documented. Examples of documentation are written file notations, statements in reports and forms. Specific legal requirements must be met at certain stages of the process. The State of Oregon has suggested forms which satisfy these requirements.

Districts reporting or keeping any information relating to a handicapped individual as defined in ORS 343.035 shall follow regulations of the Confidentiality of Handicapped Children's Records OAR 581-15-055.

Referral/Identification

The local education agency is responsible for identification of all students with speech and/or language impairment who reside in that district. Each district should have a policy written according to state and federal law outlining procedures for identification. This should define referral sources, when and how to refer and record keeping.

Any person concerned about a student's communicative abilities may refer a student for a speech-language evaluation. These persons may include the student's teacher (regular or special education), other school personnel, parents, physicians, nurses, audiologists, representatives of other agencies, or the student.

A district may elect to use a district-wide speech-language screening procedure. If a district chooses to screen, a certificated speech-language pathologist is to be responsible for selection of the population to be screened, selection of screening instruments, and interpretation of results. Any personnel trained to assist with the screening will work under the supervision of the speech-language pathologist.

Guidelines should be clearly established in each local education agency to help individuals who wish to make referrals. A written form should be completed by the referring source.

A student should be referred when any of the following conditions are met:

1. A student's communicative abilities are noticeably different from peers.

2. A student, his or her parents, and/or a teacher express concern about the student's ability to communicate.

3. A student is having difficulty with comprehension, and/or expression of oral and/or written language in academic settings.

Once a student has been referred, it is the responsibility of the speech-language pathologist to determine if the referral should result in an evaluation and to continue with evaluation procedures as outlined according to OAR guidelines. If the referral does not result in evaluation or if information concerning the referral is inadequate, the speech-language pathologist should consult with the referring source for clarification and resolution.

Districts should establish record-keeping systems to include records of students referred and the disposition of those referrals.

Diagnostic Evaluation

Evaluation is the process used to determine whether a handicap exists and to determine the nature and extent of services needed. **No evaluation procedures may begin until written parent/guardian permission is obtained and parents/guardians are informed of their legal rights.** In the absence of a parent or legal guardian or when the child is a ward of the state, a surrogate parent will be appointed under OAR 581-15-099. This person will take the place of the student's parent in due process proceedings. Written authorization for exchange of information must be obtained if another agency is involved. Reports of evaluation procedures and findings are made available to appropriate individuals and agencies.

An evaluation is:

1. an informal appraisal of performance which takes into account history, observation, and consultation with parents, teachers, and other professionals,

2. a formal appraisal of performance (tests),

3. a comprehensive appraisal which addresses all aspects of speech and language, including strengths and weaknesses, and

4. an ongoing process which considers the history of therapy, the student's motivation, and performance in the current environment.

A speech and language assessment must be administered by a certificated or licensed speech-language pathologist. The tests should relate to the concerns about the student's communication skills. Knowledge of test reliability, validity, racial and cultural fairness, and age-appropriateness is essential. Tests must be administered and scored in conformance with instructions provided by test producers. Information on these aspects of instruments are available in the technical data section of test manuals (Appendix A).

All areas of communicative function should be addressed in a speech and language assessment. This should include a variety of environments: i.e,, classroom, playground, home, etc.

A minimum of two diagnostic measures must be used as the criteria for determining eligibility or an appropriate treatment program. In addition, a person other than the speech-language pathologist must express concern about the student's communicative skills. Each evaluation will include screening of hearing, examination of the peripheral speech mechanism, speech and/or language testing and related medical information. Assessment should include: the case history, observation, consultation with parents and teachers and, when appropriate, other testing such as medical, educational and psychological evaluations. Test results should be used with caution and should not merely reflect a student's inability to perform on a specific test on a specific day.

Each district should have written guidelines for caseload selection. These guidelines define characteristics of the student's speech-language impairment on a continuum of severity. A severity index may be used to make case selection decisions and identify the student's programming needs. Use of a severity index can also result in more equitable staff assignments and a consistent delivery system throughout a district (Appendix B).

A severity index includes:

1. the range of communication skill from normal to severely impaired,

2. descriptions of communication skills in objective terms (i.e., frequency of occurrence, percentile rank, etc.),

3. consideration of prognostic indicators such as motivation, cognitive level, response to previous service, and parent/teacher involvement,

4. recommended frequency and intensity of treatment, and

5. criteria for student leaving service.

Articulation

Articulation skills should be assessed in at least two environmental contexts. Skills should be evaluated in isolation, words, sentences and/or conversation. A measure of stimulability of error sounds and a percentage estimate of intelligibility should be used. When addressing neuromotor impairments (such as cerebral palsy, dyspraxia), hearing loss or cleft palate, specific articulation skills, patterns and intelligibility of speech and/or signs should be viewed in relation to the unique characteristics of the etiology. If there has been previous service, a percentage estimate of carryover should be included.

Voice

Vocal characteristics should be examined in the areas of pitch, quality, resonance and intensity. Voice deviance will be confirmed as a continuing problem after an appropriate period of observation. An examination by an otolaryngologist or other physician will be obtained to determine whether intervention is medically contra-indicated except in cases of confirmed neuromotor involvement resulting in abnormal body muscle tone/function or abnormal vocal characteristics associated with autism, hearing impairment or dyspraxia.

Fluency

Evaluation of fluency should address, but not be limited to description of frequency (by type), duration of dysfluent behavior and secondary characteristics. Objective procedures should be chosen which reflect a particular clinical methodology and assess fluency behaviors in a variety of settings.

Language

Consideration should be given to all aspects of language (prelinguistic, expressive, receptive) including: syntactic, semantic, morphological, phonological and pragmatic skills. Procedures may include normed or criterion-referenced tests as well as a language sample. When possible, results should be computed in standard scores, language quotients, percentiles and/or stanine.

Reports

A written report should follow each evaluation and contain:

1. date of the evaluation,
2. pertinent case history and referral source,
3. description of the problem,
4. tests administered,
5. test results and clinical observations,
6. audiometric screening or results of audiologic evaluation,
7. absence of other problems (or notation of referral),
8. a summary,
9. eligibility for services and recommendations for frequency and duration of treatment,
10. prognosis, and
11. signature and title of the certificated/licensed speech-language pathologist or audiologist responsible for the evaluation report.

Progress reports (present level of performance) are prepared annually for students receiving service and contain:

1. period of time covered by the report,
2. number and length of direct treatment sessions,
3. indirect and consultation services,
4. diagnostic summary, including hearing screening,
5. summary of treatment plan,
6. summary of responses to treatment,
7. current status,
8. conclusions and recommendations, and
9. signature and title of the certificated/licensed speech-language pathologist responsible for the service.

Eligibility Determination

Eligibility is determined by the speech-language pathologist and one other service provider such as the regular/special education teacher, audiologist or psychologist, and is based on evaluation results. State and federal law require a written document of eligibility determination signed by members of the team.

Individual Education Program (IEP)

Public law has mandated that local education agencies develop and use an individual education program for each student with a speech-language impairment. The individual education program process is the method by which a handicapped student's educational program is developed. When a student has more than one handicapping condition, or requires a variety of services, **a single IEP** will list objectives to address all educational needs. Procedures for the development of an individualized education program are:

Notification/Participation

The IEP meeting must be attended by three multidisciplinary team members: a district representative, the classroom teacher and the parents/guardians. The speech-language pathologist must be present and may function as the teacher or district representative but may not function in both roles in a single meeting. Other service providers may be included as needed.

Participants must be notified of the IEP meeting with sufficient time for their inclusion in the IEP process. The notice of the IEP meeting should include the date, time, location, purpose of the meeting, and the name of persons attending. Parents/guardians may indicate if they choose not to participate in the IEP development. Attempts to involve the parents/guardians must be documented. If the local education agency is unable to obtain parent/guardian response, the IEP meeting may be conducted without their participation. In these cases the parents/guardians shall be provided with a copy of the IEP (OAR 581-15-067).

Content

The individualized education program is a written document including:

1. a statement of the student's present level of performance,
2. the annual goals, which must be written with parent/guardian participation, and finalized goals which **must be developed** at the IEP meeting,
3. short-term objectives which are measurable and act as steps between the student's present level of performance and the annual goals,
4. criteria for measuring student progress,
5. description of related services needed by the student including items such as amplification equipment, alternative communication systems, transportation, etc.,
6. the amount of time the child will spend in the regular education program,
7. the date the IEP will be initiated and the anticipated duration of the program, and
8. the names and positions of persons attending the IEP meeting (obtaining signatures of IEP participants is recommended).

Placement/Services

A student is placed in an intervention program following development of an IEP. Written parent/guardian consent for initial placement **must** be obtained.

Annual IEP Review and Revision

The IEP must be reviewed annually. The same procedures used for IEP development are implemented for the annual review.

Three Year Re-evaluation

Evaluation procedures specified in 45 CFR 121a.532 must be met for re-evaluation just as they were for initial placement evaluation. Prior notice of re-evaluation must be sent to the parent/guardian before the re-evaluation is conducted (written permission to re-evaluate is not a requirement). There must be a written document of continued eligibility signed by each member of the team.

Exit

A student may no longer be eligible for services and exit the program if the goals have been met or if review or re-evaluation indicates the student is no longer eligible. A student may exit at any time that services are contraindicated. Prior notice to the parents/guardians for any change of placement is required.

V

Delivery of Service

Communication abilities occur along a continuum from adequate to inadequate. Students may exhibit minor developmental delays, mild or moderate deviations, or severe impairments. Providing a full range of services is the responsibility of the local education agency.

Service Delivery Models

Intervention services should meet the individual needs of the student. The speech-language pathologist may use more than one service delivery model for a student. Four service delivery models that provide a continuum of services are: consultation, itinerant, resource center and self-contained classroom.

The selection of the service delivery model and the caseload size will be influenced by:

1. the number and severity of identified students,
2. the intervention recommendations specified in the IEP,
3. the number of schools served,
4. the amount of travel time between schools, and
5. the length of the school day and student availability.

Consultation Model

The speech-language pathologist in this model develops a clinical management program for the speech-language impaired student and is responsible for training and instructing others to carry out the program. The consultation model is suitable for all degrees of disorders from mild to severe.

Itinerant Model

In an itinerant model the speech-language pathologist provides direct service to students on a regular basis. Service is provided in or outside the classroom, individually or in small groups.

Resource Room Model

The resource room model is suited for all classifications of disorders; however, it is primarily designed for students with severe speech-language impairment. Direct, intensive services are provided by the speech-language pathologist. In addition, the speech-language pathologist works in cooperation with the regular/special educator to incorporate communication skill building activities into the student's total curriculum.

Self-Contained Model

The self-contained model for speech-language impairment is used for those students who are severely impaired or who have multiple speech-language impairments. In addition to more traditional duties, the speech-language pathologist in this model also provides academic instruction. The primary handicapping condition must be "language impaired" before a speech-language pathologist may teach academics in a self-contained classroom. Students in this model may be mainstreamed in regular educational settings (P.E., Music) but remain with the speech-language pathologist for most of the day.

Service Exclusions

Service is not provided to students with communication behaviors that may improve without intervention. Service is also not appropriate where there is evidence that the treatment plan has not or will not be beneficial.

Communication difference due to dialectical variations reflect shared regional or cultural/ethnic factors and should not be considered an impairment of speech-language. Limited English Proficient speakers frequently demonstrate predictable patterns of native language interference as they acquire English skills. Careful, non-biased assessment is important to differentiate language differences from suspected speech-language impairments in the dialectical and bilingual speaker.

Prevention of Speech-Language Impairment

The speech-language pathologists' unique training make them valuable resources in the prevention of speech and language impairment. Speech-language impairment may be prevented when the speech-language pathologist provides consultation and other services to students, parents and teachers, and other community members.

Use of Paraprofessionals

Paraprofessionals may be used to augment a program of intervention but not to supplant the services of a certificated or licensed speech-language pathologist. A speech-language assistant is any person who, after academic and/or on-the-job training, provides clinical services as prescribed and directed by a certificated or licensed speech-language pathologist. The assistant should be assigned tasks only at the discretion of the certificated or licensed speech-language pathologist and should not be assigned tasks for which he/she has not been trained.

The supervising speech-language pathologist must provide sufficient supervision to ensure appropriate completion of all tasks assigned to the assistant. The assistant shall not be independently responsible for communication assessment or program planning.

The supervising speech-language pathologist also maintains legal responsibility for all services provided by the assistant and must be qualified to train and supervise assistants. Minimum qualifications for this responsibility should include a master's degree in speech-language pathology, at least one year's experience in speech-language pathology and training in supervisory techniques. Guidelines for selection of assistants, minimum training standards and appropriate activities are available (Appendix D).

VI

Program Management

The Education of the Handicapped Act mandates the availability of services for handicapped students. Ongoing program management and evaluation are needed in order to provide the quality needed for students with speech or language impairments. The management program should address administrative structure, data collection, quality assurance, program management, and caseload accountability. The program evaluation should include responsibilities at the administrative, supervisory, personnel, student and support services levels.

Administration and Management

A speech-language program in the public school should have a clear, well-defined administrative structure. Figure 3 indicates personnel and responsibilities in program management.

PROGRAM MANAGEMENT

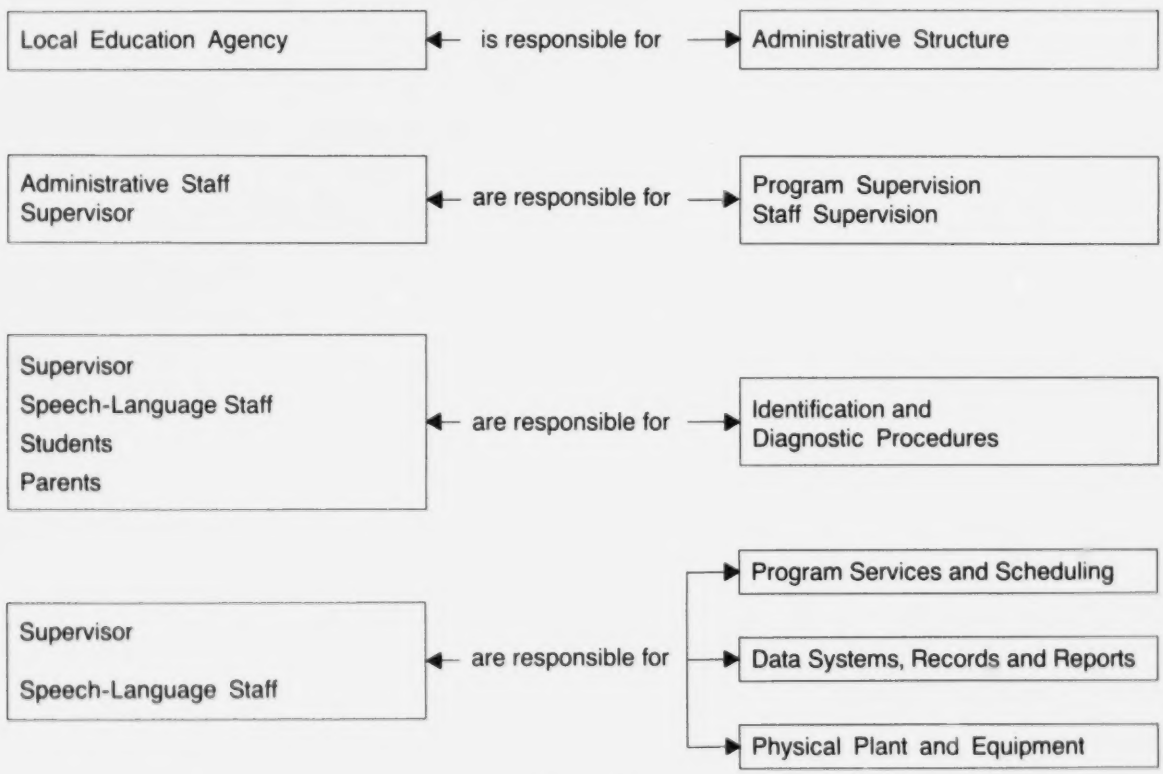

FIGURE 3

The program administrator, in cooperation with the staff, should establish the continuum of service which best meets the goals and objectives of the speech-language program. A program such as the *Planning, Development, Management and Evaluation (PDME)*[2] suggested by the American Speech-Language-Hearing Association should be implemented. This system would include a method for identification of a strategy for program development, an evaluation plan and a feedback system.

Supervision

Supervision shall be provided for the speech-language staff. Where fewer than ten speech-language pathologists are employed, a qualified staff member should be assigned coordination/supervision responsibilities on at least a part-time basis. A staff of 10-29 speech-language pathologists should have a full-time program administrator and/or supervisor trained in speech pathology and audiology. The supervisor is responsible for monitoring student services and ongoing staff development. Services shall meet the requirements of state and federal laws and local district procedures. Monitoring procedures should include review of multidisciplinary team recommendations and implementation of the individual educational programs (IEPs). The staff should be provided with inservice opportunities and resources for professional growth.

The program supervisor should provide ongoing technical assistance to staff, be accountable for program development, and monitor program effectiveness.

The supervisor should, in cooperation with appropriate administrators, be responsible for staff evaluations on a regular basis following state and local education agency guidelines (ORS 342.850). Staff evaluations should follow a clinical supervision model and should be in compliance with the standards for competent and ethical performance of Oregon educators (OAR 584-20-000 through 584-20-045).

[2] **American Speech-Language-Hearing Association.** *Planning, Development, Management, Evaluation*, 10801 Rockville Pike, Rockville, MD 20852

Staff evaluations should include a records review. There should be current records containing information about each student's placement, multidisciplinary team recommendation, individual education program, and documentation of progress in meeting the individual goals and objectives. Staff members should also keep written evaluation summaries for placement, annual reviews, and three-year re-evaluation of their student.

Program Evaluation

The broad function of program evaluation is to provide information for decision making. A properly conducted evaluation system should provide information which may be used for decisions relative to program purposes, accountability, management and planning.

Program evaluation should be ongoing, involving individuals at the administrative, supervisory, direct service, teacher and parent levels. Administrative responsibilities include program compliance with federal and state regulations and monitoring the meeting of stated goals.

Program evaluation may include: consumer satisfaction surveys, compilations of data indicating successful completion of IEP objectives, program summaries indicating percentage of program goals attained, comparative studies of intervention strategies and the relative effectiveness, and data-based reports on the services provided by the speech-language program. Program evaluation requires planning and careful documentation. In addition, those individuals who are responsible for the program evaluation must have sufficient time to complete this task.

Personnel Development

Personnel development is essential to maintain and improve the quality of services provided to students with speech or language impairments. It may include inservice activities, activities in professional organizations, and workshops. For professional growth to occur the speech-language pathologist must be given release time and financial support for participation in staff development activities.

Community Involvement

Community members can provide environmental support for the students with speech or language impairments and the program that is serving them. The community needs a basic knowledge of the educational needs and habilitation process as they relate to the academics and functioning of students in their community.

Four major resources are available to provide personnel development to these groups:

1. persons within the local education agency,
2. staff members at institutions of higher education,
3. persons with the Oregon Department of Education, and
4. persons associated with the Oregon Speech and Hearing Association and the American Speech-Language-Hearing Association.

Professionals, parents and school personnel should be committed to utilizing these resources to ensure optimum programs for the students with speech or language impairments.

VII

Facilities and Materials

Physical Plant

The program environment shall be suitably situated, constructed, furnished and maintained to assure effective professional services for students under conditions of maximum efficiency, safety, comfort and privacy. Evaluation of communication skills must take place in an environment conducive to obtaining optimal assessment information. A facility of adequate size which is relatively free from extraneous noise and visual distractions should be provided.

The size and furnishings of the facility should accommodate the delivery of speech-language services including individual and group treatment sessions; hearing screenings; classroom activities; and parent, teacher, and student conferences. Rooms should be easily accessible and barrier free. The facility should include:

1. chairs and tables of appropriate size for students and speech-language pathologist,
2. a locking file cabinet for student records to ensure the maintenance of confidentiality,
3. sufficient storage space for program materials and equipment (cabinet and bookcases),
4. access to a privately situated telephone,
5. access to clerical services,
6. electrical outlets, and
7. adequate lighting, heat and ventilation.

In addition to the basic facility various other settings may be used for therapy. These could include the student's classroom, a resource room, media center or other school settings depending on student needs and group size.

Equipment

The equipment provided should be adequate to accomplish the specific goals and objectives of the student's programs. The equipment should include:

1. a mirror,
2. an audio recorder, and
3. display boards.

There should be access to or scheduled use of:

1. an audiometer,
2. a computer for both treatment programs and record management,
3. appropriate software,
4. amplification devices,
5. copying devices, and
6. augmentative communication devices and switches.

Materials

The speech-language pathologist should be provided with a standard test battery and an adequate supply of test protocols sufficient to test in all areas of speech and language and should have easy access to less frequently used tests. An adequate budget to update tests and materials should be maintained. Sufficient age-appropriate materials for remediation of all areas of speech and language should be available. Consumable instructional materials such as pencils, pens, paper, transparencies, duplicating paper, floppy disks and school texts should be supplied.

VIII

Appendix

Appendix A

TEST INFORMATION

1. Test Review Forms. These examples may assist speech-language pathologists in determining appropriate evaluation instruments.
2. Evaluation Instruments for Speech and Language. This list is not exhaustive; publishers are listed to assist in locating specific tests.
3. Selected Excerpts from the "Joint Technical Standards for Educational and Psychological Testing," fourth draft, 1984; Published through APA.
4. Normal Distribution Curve

Appendix B

SEVERITY RATING SCALES

1. Districts and Education Service Districts in Oregon Using Self-Developed Severity Rating Scales
2. Clatsop Education Service District
   3194 Marine Drive
   Astoria, OR 97103-2799
3. Eugene Public Schools
   200 North Monroe
   Eugene, OR 97204-4295
4. Portland Public Schools
   Special Education
   Speech Pathology
   531 SE 14th Street
   Portland, OR 97214
   Attention: Corinne Thomas-Kersting
5. Umatilla Education Service District
   412 SE Dorion Street
   PO Box 38
   Pendleton, OR 97801-0038
   Attention: Marsha Stipe

NOTE: Contact school districts for complete documents.

Appendix C

GUIDELINES FOR CASELOAD SIZE

Appendix D

GUIDELINES FOR SUPPORTIVE PERSONNEL

Sample Form

TEST REVIEW FORM

CHARACTERISTICS OF SELECTED SPEECH-LANGUAGE TESTS

TEST	ASPECTS TAPPED	AGE RANGE	NORMS GIVEN	SAMPLE POPULATION	ETHNIC USE	RELI-ABILITY	VALIDITY	ADMINIS-TRATION TIME	APPROPRIATE ADMINIS-TRATION	INFORMA-TION SOURCE	DETERMINE ELIGIBILITY	DETERMINE PLACE
Clinical Evaluation of Language Functions (CELF) Diagnostic	Phonology Syntax Semantics Memory Word Finding	NG Grade level only	No	159	NG	+ week	+ week	75 min.	Diagnostic personnel	Direct student observation	Yes	Yes
Compton Hutton Phonological Assessment	Articulation by distinctive feature analysis	3 years to adult performance	No	200	NG	NG	NG	40-60 minutes adminis analysis (20-25 admin. only)	Speech-language pathologist	Direct student observation	Yes	Yes
Fisher-Logeman Test of Articulation Competence	Articulation to test subject phonological systems in an orderly framework and analyze articulation errors	NG	No	NG	NG	NG	NG	NG	Speech-language pathologist	Direct student observation	Yes	Yes
Test of Language Development Primary (TOLD)	1. receptive vocabulary 2. expressive vocabulary 3. grammatical understanding (assesses child's ability to comprehend the meaning of sentences)	4 0 8-11	Yes	Normal varied "typical geography Eng." multistate	Anglo Black	Yes	Yes	30 minutes to 1 hour	Teachers, counselor, psychologist, language therapist or other professionals who have experience in test administration	Direct student observation	Yes	Yes

NG = Not given in manual

Source of document is unknown

TEST REVIEW FORM

NAME OF TEST _____

PUBLISHER _____ DATE OF PUBLICATION _____

Area(s)/skill(s) covered: e.g., Articulation, Syntax, etc. _____

_____

Age range of test: _____ Group ____ Individual ____

Criterion-referenced _____ Norm-referenced _____

Type of scores: e.g., Grade Equivalent, Standard Score, Percentile, etc. _____

_____

_____

Publisher's recommendations for examiner's qualifications: _____

_____

Approximate length of time for administration _____ Timed ____ Untimed ____

Utilization: to determine eligibility _____ for programming _____

STANDARDIZATION INFORMATION

Date of Standardization _____

Sample description:

A. Geographic _____
B. Socio-economic status _____
C. Ethnicity _____
D. Size _____
E. Rural-Urban _____
F. Type of population, e.g., Deaf-Blind, regarded, normal, etc. _____
_____
G. Primary language of sample _____

STATISTICAL DATA

A. Reliability - How measured, what coefficients _____
B. Validity - How validated, what coefficients _____
C. Measures of central tendency
   1. Mean _____
   2. Standard deviation _____
   3. Standard error of measurement _____

DESCRIPTION OF SCALE

Single scores/subtest scores _____
_____

Mode of presentation _____
_____

GENERAL CONSIDERATIONS

Specific test constraints: e.g., How many subtests must be used to yield valid total?

_____
_____
_____

Under what circumstances can clear inference be drawn about subtest score deviance?

_____
_____

Other _____
_____

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Appendix A
Item 2

EVALUATION INSTRUMENTS FOR SPEECH AND LANGUAGE

This list is not exhaustive; publishers are listed to assist in locating specific tests.

ARTICULATION

A Deep Test of Articulation — McDonald. Communication Skill Builders.

Arizona Articulation Proficiency Scale: Revised. Western Psychological Services.

The Assessment of Phonological Processes (APP-R) Hodson. Slosson Educational Pub., Inc.

Fisher-Logemann Test of Articulation Competence. The Riverside Publishing Co.

Goldman-Fristoe Test of Articulation. American Guidance Service.

Phonological Process Analysis (PPA) Weiner. Slosson Educational Pub., Inc.

Photo Articulation Test (PAT). Slosson Educational Pub., Inc.; McGraw-Hill; Academic Therapy Publications.

Weiss Comprehensive Articulation Test (WCAT). DLM/Teaching Resources.

VOICE

Jewish Hospital Voice Profile — Wilson & Rice. Unpublished; see ASHA Publication "Speech Language Services In the Schools," 4, pp 14-22.

FLUENCY

Stuttering Prediction Instrument (SPI) Riley. Pro-Ed.

The Stuttering Severity Index (SSI) Riley. Pro-Ed.

LANGUAGE

Boehm Test of Basic Concepts — Revised (Boehm-R). The Psychological Corp.

Bracken Basic Concept Scale (BBCS). The Psychological Corp.

Callier-Azusa Scales G and H. Callier Center for Communication Disorders, University of Texas at Dallas.

Carrow Elicited Language Inventory (CELI). DLM/Teaching Resources.

Clinical Evaluation of Language Fundamentals — Revised (CELF-R). The Psychological Corp.

Daberon Screening Device for School Readiness. Pro-Ed.

Evaluating Communicative Competence. Communication Skill Builders.

Expressive One-Word Picture Vocabulary Test, (EOWPVT). Academic Therapy Publications Consulting Psychologists Press, Inc.; McGraw Hill; Slosson Educational Pub., Inc.

Expressive One-Word Picture Vocabulary Test Upper Extension (EOWPVT-UE). Academic Therapy Publications Consulting Psychologists Press, Inc.; McGraw-Hill; Slosson Educational Pub., Inc.

Fullerton Language Test for Adolescents (FLTA). Academic Therapy Publications Consulting Psychologists Press, Inc.; McGraw-Hill; Slosson Educational Pub., Inc.

Generic Skills Assessment. Bureau of Child Research, University of Kansas.

Interaction Checklist for Augmentative Communication (INCH). INCH Associates.

Interpersonal Language Skills Assessment (ILSA). LinguiSystems, Inc.

Language Processing Test (LPT). LinguiSystems, Inc.

The Nonspeech Test for Receptive/Expressive Language. Don Johnson Developmental Equipment, Inc.

Non-Verbal Prelinguistic Communication. Oregon Department of Education.

The Preverbal Assessment-Interaction Profile (PAIP). Pro-Ed.

Peabody Picture Vocabulary Test Revised (PPVT-R). American Guidance Service.

Preschool Language Scale (PLS) Zimmerman. The Psychological Corp.

Receptive One-Word Picture Vocabulary Test (ROWPVT). Slosson Educational Pub., Inc.

Screening Test of Adolescent Language (STAL). Slosson Educational Pub., Inc.

Sequenced Inventory of Communication Development — Revised (SICD). Slosson Educational Pub., Inc.; Western Psychological Services.

Structured Photographic Expressive Language Test — Preschool (SPELT-P). Janelle Publications.

Structured Photographic Expressive Language Test-II (SPELT-II). Janelle Publications.

Test for Auditory Comprehension of Language — 1985 Revised (TACL-R). DLM/Teaching Resource.

Test of Early Language Development (TELD). American Guidance Service.

Test of Language Competence — Expanded. The Psychological Corporation.

Test of Language Development — Intermediate (TOLD-I). The Psychological Corp.; DLM/Teaching Resources; Slosson Educational Pub., Inc.; American Guidance Service.

Test of Language Development — Primary (TOLD-2). The Psychological Corp.

Test of Problem Solving (TOPS). LinguiSystems, Inc.

The Word Test. LinguiSystems, Inc.

TESTS WHICH MAY BE USED FOR SUPPORTIVE DATA

Auditory Memory Span Text Wepman. Western Psychological Services.

Auditory Sequential Memory Test Wepman. Western Psychological Services.

Detroit Tests of Learning Aptitude (DTLA-2). Slosson Educational Pub., Inc.

Goldman-Fristoe-Woodcock Auditory Skills Test Battery. American Guidance Service.

Illinois Test of Psycholinguistic Abilities (ITPA). Slosson Educational Pub., Inc.

Lindamood Auditory Conceptualization Test. DLM/Teaching Resources.

Porch Index of Communicative Ability in Children (PICA). Consulting Psychologists Press, Inc.

Token Test for Children. DLM/Teaching Resources.

Revised Token Test (RIT). Slosson Educational Pub., Inc.

Test of Word Finding (TWF). DLM/Teaching Resources.

Token Test for Children. DLM/Teaching Resources.

Wepman Auditory Discrimination Test, 1973 Revision. Western Psychological Services.

ALPHABETICAL LISTING OF PUBLISHERS

Academic Therapy Publications
20 Commercial Boulevard
Novato, CA 94947-9986

American Guidance Service
Publishers' Building
PO Box 99
Circle Pines, MN 55014-1796

Bureau of Child Research
University of Kansas
Parsons, KS 67357

Callier Center for Communication Disorders
University of Texas at Dallas
1966 Inwood Road
Dallas, TX 75235

Communication Skill Builders
3830 E Bellevue
PO Box 42050
Tucson, AZ 85733

Consulting Psychologists Press, Inc.
577 College Avenue
Palo Alto, CA 94306

CTB/McGraw-Hill
Publishers Test Service
2500 Garden Road
Monterey, CA 93940-5380

Don Johnson Developmental Equipment, Inc.
900 Winnetka Terrace
Lake Zurich, IL 60047

DLM/Teaching Resources
One DLM Park
PO Box 4000
Allen, TX 75002

Inch Associates
9568 Hamilton Avenue
Suite 104
Huntington Beach, CA 92646

Janelle Publications
PO Box 12
Sandwich, IL 60548

LinguiSystems, Inc.
716 17th Street
Moline, IL 61265

Oregon Department of Education
Attention: Maurine Otos
700 Pringle Parkway SE
Salem, OR 97310-0290

Pro-Ed
8700 Shoal Creek Blvd.
Austin, TX 78758-6897

Slosson Educational Publications, Inc.
PO Box 280
East Aurora, NY 14052

The Psychological Corporation
PO Box 9954
San Antonio, TX 78204-0954

The Riverside Publishing Company
1919 South Highland Avenue
Lombard, IL 60148

Western Psychological Services
12031 Wilshire Blvd.
Los Angeles, CA 90025

Appendix A
Item 3

Selected Excerpts from the
Standards for Educational and Psychological Testing
1985
American Educational Research Association
American Psychological Association
National Council on Measurement in Education

Chapter 1 Validity

Standard 1.1 Evidence of validity should be presented for the major types of inferences for which the use of a test is recommended. A rationale should be provided to support the particular mix of evidence presented for the intended uses. *(Primary)*

Standard 1.8 When a test is proposed as a measure of a construct, that construct should be distinguished from other constructs; the proposed interpretation of the test score should be explicitly stated; and construct-related evidence should be presented to support such inferences. In particular, evidence should be presented to show that a test does not depend heavily on extraneous constructs. *(Primary)*

Standard 1.23 When a test is designed or used to classify people into specified alternative treatment groups (such as alternative occupational, therapeutic, or educational programs) that are typically compared on a common criterion, evidence of the test's differential prediction for this purpose should be provided. *(Secondary)*

Standard 1.24 If specific cut scores are recommended for decision making (for example, in differential diagnosis), the user's guide should caution that the rates of misclassification will vary depending on the percentage of individuals tested who actually belong in each category. *(Primary)*

Chapter 2 Reliability and Measurement Error

Standard 2.1 For each total score, subscore, or combination of scores that is reported, estimates of relevant reliabilities and standard errors of measurement should be provided in adequate detail to enable the test user to judge whether scores are sufficiently accurate for the intended use of the test. *(Primary)*

Standard 2.3 Each method of estimating a reliability that is reported should be defined clearly and expressed in terms of variance components, correlation coefficients, standard errors of measurement, percentages of correct decisions, or equivalent statistics. The conditions under which the reliability estimate was obtained and the situations to which it may be applicable should also be explained clearly. *(Primary)*

Standard 2.9 Where there are generally accepted theoretical or empirical reasons for expecting that reliabilities or standard errors of measurement differ substantially for different populations, estimates should be presented for each major population for which the test is recommended. *(Conditional)*

Chapter 4 Norms

Standard 4.1 Scales used for reporting scores and the rationale for choosing them should be described clearly in test publications to facilitate accurate interpretation of scores by both the test user and the test taker. A publication should specify how scaled scores are derived from raw scores. *(Primary)*

Standard 4.3 Norms that are presented should refer to clearly described groups. These groups should be the ones with whom users of the test will ordinarily wish to compare the people who are tested. Test publishers should also encourage the development of local norms by test users when the published norms are insufficient for particular test users. *(Conditional)*

Standard 4.5 When it is expected that a test will be used to make norm-referenced assessments of groups rather than individuals, normative data based on appropriate group statistics should be provided. *(Secondary)*

Chapter 5 Responsibilities of Test Makers

Standard 5.2 Test manuals should describe thoroughly the rationale for the test, state the recommended uses of the test, and provide a summary of the support for such uses. Where particular misuses of a test can be reasonably anticipated, the test manual should provide specific cautions against such misuses. *(Primary)*

Standard 5.4 Test manuals should identify any special qualifications that are required to administer a test and to interpret it properly. Statements of user qualifications should identify the specific training, certification, or experience needed. *(Primary)*

Standard 5.7 Promotional material for a test should be accurate. Publishers should avoid using advertising techniques that suggest that a test can accomplish more than is supported by its research base. *(Primary)*

Chapter 6 General Principles of Test Use

Standard 6.1 Tests users should evaluate the available written documentation on the validity and reliability of tests for the specific use intended. *(Primary)*

Standard 6.4 Test users should accurately portray the relevance of a test to the assessment and decision-making process and should not use a test score to justify an evaluation, recommendation, or decision that has been made largely on some other basis. *(Primary)*

Standard 6.7 Test users should verify periodically that changes in populations of test takers, objectives of the testing process, or changes in available techniques have not made their current procedures inappropriate. *(Conditional)*

Standard 6.10 In educational, clinical, and counseling applications, test administrators and users should not attempt to evaluate test takers whose special characteristics—ages, handicapping conditions, or linguistic, generational, or cultural backgrounds—are outside the range of their academic training or supervised experience. A test user faced with a request to evaluate a test taker whose special characteristics are not within his or her range of professional experience should seek consultation regarding test selection, necessary modifications of testing procedures, and score interpretation from a professional who has had relevant experience. *(Primary)*

Standard 6.11 In school, clinical, and counseling applications, a test taker's score should not be accepted as a reflection of lack of ability with respect to the characteristic being tested for without consideration of alternate explanations for the test taker's inability to perform on that test at that time. *(Conditional)*

Standard 6.12 In school, clinical, and counseling applications, tests developed for screening should be used only for identifying test takers who may need further evaluation. The results of such tests should not be used to characterize a person or to make any decision about a person, other than the decision for referral for further evaluation, unless adequate reliability and validity for these other uses can be demonstrated. *(Primary)*

Chapter 8 Educational Testing and Psychological Testing in the Schools

Standard 8.12 In elementary or secondary education, a decision or characterization that will have a major impact on a test taker should not automatically be made on the basis of a single test score. Other relevant information for the decision should also be taken into account by the professionals making the decision. *(Primary)*

Terms:

Primary — those that should ideally be met by all tests before they are used, unless a sound reason is available as to why this is not necessary.

Secondary — desirable, but are likely to be beyond reasonable expectation in many situations.

Conditional — importance of these will vary with application. Considered primary for some situations, secondary in others.

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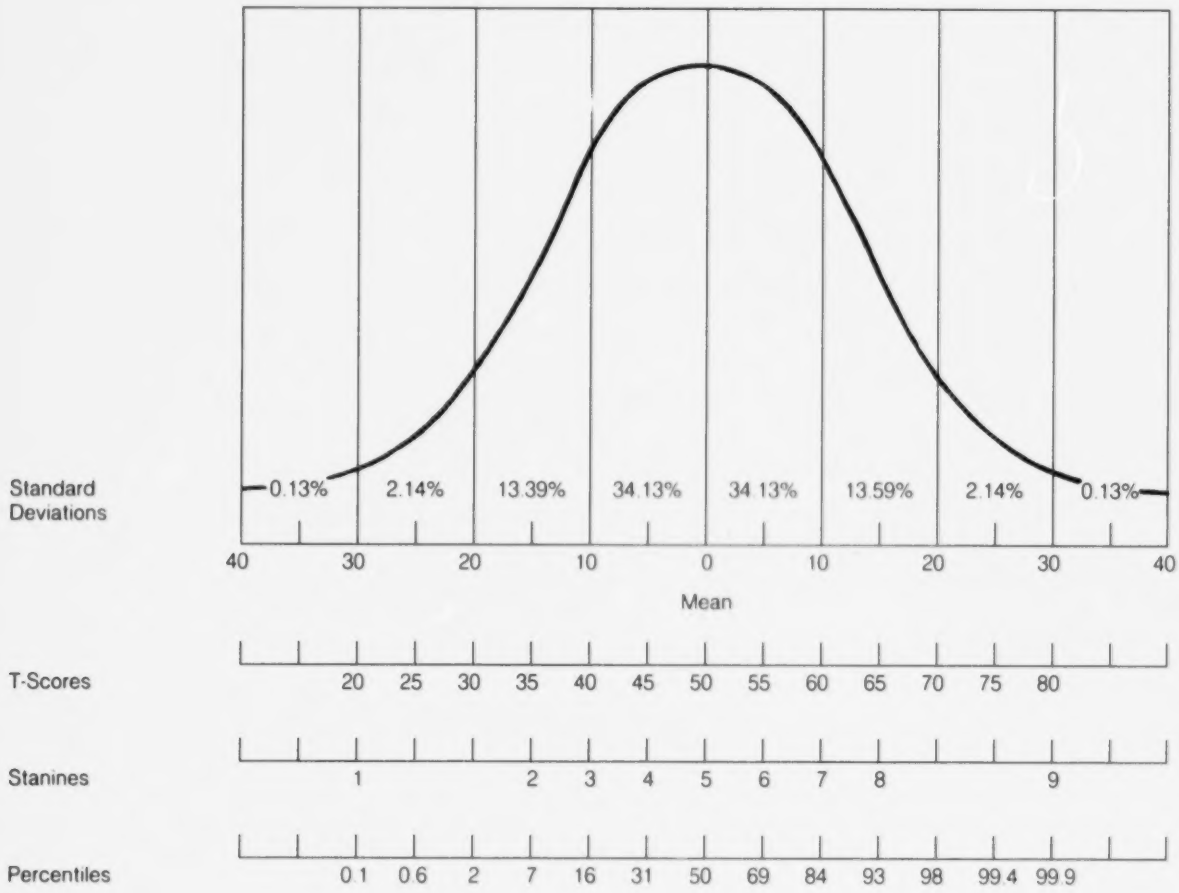
Appendix A
Item 4

NORMAL DISTRIBUTIVE CURVE

Bell shaped curve representing the theoretical distribution of an infinitely large number of scores with deviation from the mean only by chance.



DISTRICTS AND EDUCATION SERVICE DISTRICTS IN OREGON USING SEVERITY INDICES

Clatsop Education Service District
3194 Marine Drive
Astoria, OR 97103-2799
Attention: DonnaMary Dulcich

Eugene School District 4J
200 North Monroe Street
Eugene, OR 97402-4295
Attention: Nancy Warnock

North Clackamas School District
1903 SE Oak Grove Blvd.
Milwaukie, OR 97267
Attention: Carol Middleton

Portland Public Schools
Special Education
Speech Pathology
531 SE 14th Street
Portland, OR 97214
Attention: Corinne Thomas-Kersting

Reynolds School District
Fairview Elementary
PO Box 39
Fairview, OR 97024
Attention: Pat Jensen

Umatilla Education Service District
412 SE Dorion Street
PO Box 38
Pendleton, OR 97801-0038
Attention: Marsha Stipe

RECOMMENDED PROVISION OPTIONS SERVICE

1. RECOMMEND TIME GUIDELINES FOR MOST CHILDREN ELIGIBLE FOR SERVICE.

USING SEVERITY RATING SCALE TOTAL OF ALL CATEGORIES	TIME RANGES FOR SERVICE
0 - 4	up to 40 min. per week* (MPW)
5 - 10	20 - 60 MPW
11 - 20	40 - 80 MPW
21 - 30	60 -100 MPW
31 up	80 - up MPW

*Other options could include: consultation, monitoring, bi-weekly or monthly sessions to reinforce carryover, etc.

2. FACTORS THAT MAY INFLUENCE TREATMENT TIME OR MAY CONTRAINDICATE INTERVENTION THOUGH AN IDENTIFIED SPEECH PROBLEM EXISTS.

   A. Identified speech deviation does not interfere with the child's educational, social, or emotional progress and, therefore, cannot be considered a handicap.
   B. Interference of physiological factors.
   C. Other areas of service need to precede speech/language service, if treatment is to be beneficial.
   D. Immaturity may prohibit progress.
   E. When viewing the child's needs as a whole, other educational needs have priority.

   A child may be dismissed from services, through an I.E.P. conference, when the goals and objectives have been met and no new ones are needed, or when one of the above factors has priority.

3. CONSIDERATIONS IN IMPLEMENTING OPTIONS FOR INDIVIDUAL CHILDREN.
   A. When a factor that would contraindicate intervention is present,the problem should still be identified. Note the reason service is not indicated at this time on the IEP.

   B. The factors that may influence the amount and type of service should be considered for each child when the IEP is written. The Least Restrictive Environment mandate requires justification for the amount of time the child is missing in his regular education program. This requirement can be a consideration when dismissal may be indicated, although a problem still exists.

ARTICULATION SEVERITY RATING SCALE

Developmental ages for phoneme mastery -(Sander JSHD-Feb 1972)
Age 3 - m p w n h
Age 4 - d b g k f j
Age 5 - Sibilants emerging but lingualization or lateralization may be present

Age 6 - l r t ŋ
Age 7 - ð ʃ ʧ ʤ
Age 8 - s z v θ (ð+ ʒ)

	(1) Mild	(2) Mild-Moderate	(3)Moderate	(4) Moderate-Severe	(5) Severe
I. SKILLS (ASSUMES CA = MA)	Up to 50% of phonemes for MA are deviant in 2 or more positions; phonemes below MA meet age criteria.	50% or more of phonemes for MA are deviant in 2 or more positions; below MA meet age criteria.	50% or more of phonemes at MA and/or up to 50% of phonemes 1 year below are deviant in 2 or more positions.	50% or more of phonemes at MA and/or 50% or more of phonemes 1 year below are deviant.	50% or more of phonemes at MA and below, and/or phoneme(s) 2 or more years below are deviant.
	Carryover 90% to 100% during therapy sessions, 75-90% in other speech situations.	Carryover 75-90% during therapy sessions, 50-70% other speech situations.	Carryover 50-75% during therapy sessions, 25-50% in other speech situations.		
II. STIMULABILITY	Sounds easily stimulable in isolation and words.	Sounds easily stimulable in isolation and with effort in words.	Stimulable with effort in isolation and words.	Stimulable with effort in isolation and rarely in words.	Rarely stimulable in isolation or words.
III. INTELLIGIBILITY AND QUALITY OF SPEECH	Inconsistent errors not affecting intelligibility; little or no effect on quantity or quality of communication.	Some errors present consistently; may be noticeable to experienced listener, not affecting intelligibility; may have occasional effect on quantity.	Generally intelligible but may be noticeable to majority of listeners; may limit quantity in specific settings due to articulation disorder.	Intelligible if subject is known and/or significantly distracting to content; may frequently limit quantity due to articulation disorder.	Consistently unintelligible; isolated words may occasionally be intelligible; may rarely initiate verbal communication due to articulation disorders.

FLUENCY SEVERITY RATING SCALE

Use method A for both parts I and II or use method B for both parts I and II.

		(1) MILD	(2) MILD-MODERATE	(3) MODERATE	(4) MODERATE-SEVERE	(5) SEVERE
I. A)	*FREQUENCY OF BLOCKS (include prolongations and repetitions)	2% - 5%	6% - 10%	11% - 18%	19% - 24%	25% or more
	OR					
B)	STUTTERED WORDS PER MINUTE	.6 - 5		6 - 10		11+
II. A)	*DURATION - Average of three longest blocks of the sample.	up to 1 sec.	2 - 4 secs.	5 - 9 secs.	10 - 15 secs.	16 secs. or more
	OR					
B)	TOTAL WORDS SPOKEN PER MINUTE	90 - 99		70 - 89		69 -
III.	SECONDARY CHARACTERISTICS: Include distracting sounds, head or movements of the extremities, facial grimaces, avoidance reactions, etc.	Not noted by average person		Distracts from content of communication		Displays obvious/severe secondary characteristics

*Recommended Procedure: Tape record speech samples of 200 words minimum for baseline. Tally frequency of blocks to compute percentage. Average 3 longest blocks to determine duration.

VOICE SEVERITY RATING SCALE

Scale of Laryngeal Quality (Wilson & Rice) -4 Aphonic, -3 Whisper, -2 Breathy, 1 Normal, +2 Tension, +3 Undue Tension

	(1 & 2) Treatment not indicated	(3) Moderate	(4) Moderate-Severe	(5) Severe
I. SKILLS	Includes the +2 to -2 range on the scale of Laryngeal Quality (L.Q.). Slight pitch and/or resonance variations may be present. Voice difference is not noted by casual listener	Range includes combinations of +3, +2, -2, -3 L.Q. rating. Voice quality may be harsh or raspy; pitch breaks may occur. Pitch may be inappropriate for age/sex. Resonance may be hyper/hyponasal. Voice difference calls attention to itself.	Includes +3 and/or -3 L.Q. rating, sometimes with -4 (aphonic) characteristics. Frequent pitch breaks interfere with vocal continuum. Hyper/hypo-nasality interferes with intelligibility.	Includes +3 and/or -4 ratings on L.Q. scale. Vocal production is extremely limited or non-existent
II. ETIOLOGY-CURRENT PHYSICAL CONDITIONS	No consistent laryngeal pathology. Physical factors including quality, resonance, or pitch, if present at all, are temporary and may include: allergies, colds, abnormal tonsils, adenoids, short-term abuse or misuse.	Laryngeal pathology may be present; medical evaluation may be indicated. Physical factors may include: nodules, polyps, ulcers, edema, partial paralysis of vocal folds, palatal insufficiency, enlarged/insufficient tonsils and/or adenoids, neuromotor involvement, or hearing loss. *	Probable presence of laryngeal pathology; medical evaluation usually indicated. Physical factors indicated in moderate (3) and/or severe (5) levels may be present.	Physical factors may include: -unilateral or bilateral paralysis of vocal folds -laryngectomy -psychosomatic disorders -neuromotor involvement of laryngeal muscles (i.e. cerebral palsy) Medical evaluation generally indicated.
III. INTERFERENCE WITH COMMUNICATION	None	Distracting to most listeners	Effective verbal communication is limited	No effective vocal/verbal communication.

*Voice problems related to hearing loss may require differential diagnosis and treatment.

LANGUAGE SEVERITY RATING SCALE - EXPRESSIVE

SKILLS: Vocabulary, concept development, syntax, morphology, word retrieval, sequencing, problem solving, MLU.

	(1) Developmental 0-1 SD	(2) Mild 1-2 SD	(3) Moderate 1.5-2.0 SD	(4) Severe 2.0-3.0 SD	(5) Extreme 3 SD or More
Early childhood - 3 to 6 Years	Inconsistent in: -(less than 60% correct use of) pronouns, copular/auxiliary verbs, wh-question forms. Some effect on amount of verbal output may be noted.		Inconsistent in: -(less than 60% correct use of) plurals, prepositions, present progressive forms. Limited spontaneous language; noticed primarily as shortened sentence length and tendency to respond rather than initiate conversation.		Limited use or absence of early developing language structures; spontaneous MLU of 3.0 or less. Nonverbal or extremely limited use of verbal communication.
Elementary - 6 - 10 Years	Inconsistent in, but more than 60% use of syntactic structures such as infinitives, N-V agreement, and conjunctions. Effect on amount of verbal output varies; seen frequently in shortened or incomplete sentences. Social/educational performance may be affected.		Problem areas may include: -responses to wh-questions; -use of syntactic structures (less than 60% correct); -labeling of common pictures by function, class or attribute; -verbal problem solving; -sequencing information verbally. Social/educational performance affected.		Limited use of questions and syntactic structures such as verb forms, pronoun, and prepositions. Unable to: -verbally classify by function, category, or attribute; -express basic concepts Limited expressive skills interfere with educational/social performance.
Secondary - 10 Years and up	Speech patterns are characterized by limited vocabulary (i.e., short sentences and word retrieval problems). Inconsistent in, but not less than 75% correct use of verb forms, adverbs, adjectives and other descriptive words. Difficulty using causal and conditional forms (i.e., why-because, if-then).		Problem areas include: -inappropriate use of wh-questions; -less than 70% correct use of embedded sentences, passive verb forms, conjunctions, complex noun and verb phrases. Diminished use of verbal skills affects educational/social performance.		Uses only simple sentence structure. Unable to: -answer wh-quesions; -solve problems verbally with correct detail; -label by function, class or attribute. Lack of mature expressive skills limits educational/social performance.

LANGUAGE SEVERITY RATING SCALE - PRAGMATICS

	(1) Mild 0 - 1.5 SD	(2) Moderate 1.5 - 2.0 SD	(3) 2.0 - 3.0 SD	(4) 2.5 - 3.0 SD	(5) 3 SD or more
Early Childhood 3 - 6 yrs.	Seldom: -asks for information; - relates more than one aspect of an object when asked (3 or 4 years); -maintains conversation past one response (3 or 4 years); -adapts speaking style to change in listeners. Does not understand turn taking or role playing of familiar people (4 to 6 years).		Difficulty: -relating experiences; -controlling environment verbally; -interacting socially; -using words/sentences to properly express meaning; -using prosodic characteristics. See also characteristics of "mild in this age range."		Rarely uses speech/language to: -express wants and needs; -gain attention; -defend self and property. Rarely uses inflection to enhance meaning.
Elementary 6 - 10 yrs.	Does not: -adapt speaking style to changing situations; -give feedback to speaker (i.e. nodding, "huh", "yes", "really?"); -take turns (frequent interrupting).		Difficulty: -initiating interaction; -asking for additional information; -using appropriate eye contact; -maintaining topic of conversation -using appropriate facial expression; -changing prosodic features to give meaning.		Does not use speech/language appropriately to: -gain attention; -control environment; -interact socially; -maintain conversation (asking for/providing additional information). Voice is monotone with little inflection. Insensitive to social implications of what is said.
Secondary 10 yrs. +	Does not: -adapt speaking style/content to changing situations; -perceive subtle differences in prosodic characteristics (i.e. "going home" vs "going home?"); -use appropriate rate and intonation patterns for context; - use appropriate body language (eye contact, proximity to listener/speaker, gestures, etc.) but does recognize them in others.		Does not: -use change in prosodic features to give meaning (monotone); -maintain topic of conversation (tends to ramble); -use body language effectively or appropriately. Content often has too little or inappropriate information. See also characteristics of "mild".		Cannot: -use inflection (monotone, flat, boring); -react to or demonstrate appropriate vocal intonations, rhythmic patterns or meaningful gestures; -understand communicative protocol (turn taking, eye contact, etc.); -sequence information; -maintain topics (contributions are irrelevent, off-subject and/or inappropriately short or long.

PRAGMATICS:
Topic Maintenance
Eye Contact
Proximity to Listener
Communicative intent/function of Language:
label,
respond,
greet,
request,
protest,
repeat,
describe,
practice,
attend
Contingent Queries
Turn Taking

NOTE: Pragmatic features should be evaluated at four levels:
a) formal vs. informal
b) work vs. social
c) familiar vs. unfamiliar
d) equal vs. unequal (Peers vs. adults)

NOTE: Characteristics tend to "accumulate along the continuum so that a ranking of "severe" might include the abilities/inabilities of mild and moderate even though they are not listed under that heading. Assumes CA=MA.

LANGUAGE SEVERITY RATING SCALE - RECEPTIVE

SKILLS: Vocabulary, concept development, classification, auditory processing, comprehension of syntax and morphology, comprehension of nonverbal communication, sequencing.

	(1) Developmental 0-1 SD 25%ile 4+ stanine	(2) Mild 1.0 - 1.5 SD 80-85 LQ 11-22%ile 3 stanine	(3) Moderate 1.5 - 2.0 SD 70-79 LQ 3-10%ile 2 stanine	(4) Severe 2.0 - 3.0 SD Below 69 LQ Below 3%ile 1 stanine	(5) Extreme 3.0 SD or more
Early childhood - 3 to 6 Years	Inconsistent in: -comprehension of wh- questions; -ability to complete 2 stage commands in sequence; -knowledge of size, spatial, quantity and function concepts		Unable to: -classify common objects/pictures by function, class, similarity, size, shape, quantity; Inconsistent in pointing to common objects, attributes, activities. Skills affect educational/social performance.		Unable to: -consistently respond to yes/no questions; -classify by name and function; -follow 1 step commands Does not understand space, time or quantity.
Elementary - 6 - 10 Years	Inconsistent in: -comprehension of wh- questions; -comprehension of space, time and quantity concepts; -ability to complete 3 to 4 stage commands in sequence Skills may affect educational/social performance.		Problem areas may include: -comprehension of basic concept skills; -classification of common pictures/words by function, class or attributes; -problem solving; sequencing (pictures/written material); -ability to follow 3 to 4 stage commands in sequence Skills affect educational/social performance.		Unable to: -classify objects, pictures or words by name, function or attributes; -comprehend basic concepts Difficulty comprehending and sequencing details in formal language. Limited receptive language skills interfere with educational/social performance.
Secondary - 10 Years and up	Difficulty with: -word retrieval; -comprehension of conditional and causal forms; -abstract reasoning skills		Problem areas include: -comprehension of reasons for similarities/differences; -knowledge/usage of space, time and quantity concepts; -inappropriate responses to wh- questions reflecting lack of comprehension; -comprehension of cause and effect relationships		Unable to: -relate time, space and quantity concepts to real life situations; -understand wh- questions; -sequence; -classify by function, category or attribute Inability to comprehend adult language forms limits educational/social performance.

Adapted from: Blackhawk Area Special Education, East Moline, Illinois

Appendix B
Item 2

EUGENE PUBLIC SCHOOLS
EUGENE, OREGON

SPEECH/LANGUAGE SERVICES
SEVERITY RATING SCALES

Speech and language services are provided for students attending the Eugene School District who exhibit communicative deficiencies. These communicative deficiencies are further described as deficiencies of articulation, voice, fluency and/or language.

All students must meet eligibility criteria as established by federal, state and local guidelines.

Eligibility as a student with a communicative deficiency shall be determined by a multidisciplinary team. The team shall include two or more individuals, as least one of whom shall be a specialist knowledgeable and experienced in the education of students with the suspected disability.

The following are minimum requirements to determine eligibility:

1. A speech and language assessment administered by a certificated or licensed speech and language pathologist;
2. A physician's statement by an otolaryngologist or other physician licensed by a State Board of Medical Examiners when the student has a suspected voice disorder or when a medical diagnosis is needed; and
3. A hearing screening.
4. Other information related to the student's suspected disability shall be obtained when the minimum requirements do not adequately assess the problem.

Eligibility Criteria

1. Speech and language eligibility is based on two or more assessment instruments. Formal assessment instruments should be used whenever feasible.
2. The results of all assessment are looked at together to determine the amount of service needed.
3. Each student is given a priority rating of 1, 2 or 3. A priority rating of 1 indicates the most severe deficiency and, therefore, will need the most intervention.
4. Priority ratings of 1 and 2 will result in direct intervention in small groups or one-to-one instruction.
5. A priority rating of 3, the less severe deficiencies, may receive direct or indirect intervention or a combination of both throughout a school year. Some students with a priority rating of 3 may be seen for more intense direct intervention for a portion of the year (a trimester) and receive indirect intervention (monitoring) the remainder of the year.
6. Amount of service needed for remediation of deficiencies will be translated into number of intervention units annually. This will ensure consistency of instruction time while allowing flexibility in scheduling.

Intervention Time

The following guidelines are to be used when computing service time for Individualized Education Programs (IEP). Although professional judgment is the final determiner when recommending intervention time, it is generally agreed among the Speech and Language Specialists that intervention time is related to the severity of the communication delay, i.e., the greater the communication delay, the greater the service needs.

Intervention Units

Services provided by the Speech and Language Specialists are conducted in units of 20 minutes. These traditional units of time will be referred to as Intervention Units and will be used for estimating and tracking service needs on the IEP.

Annual Intervention Time

In order to insure adequate programming for the students and flexible scheduling for the Speech and Language Specialists, intervention time for the IEP will be computed on an annual basis.

To allow time for other job-related activities (screening, assessment, assessment reports, IEP development) it is assumed that each school year 30 weeks of intervention time can be provided by a staff person.

Anticipated Schedule Interruptions

During the course of a school year, there are many planned and unplanned interruptions to the school day schedule, i.e., field trips, assemblies and/or illnesses. To allow for these and other scheduling problems, a range should be used when recording intervention units on the IEP. This range should not be less than 80% of any student's needs.

The range can be computed by multiplying .80 times the recommended intervention units.

ELEMENTARY LANGUAGE

DEFINITION

A language deficiency is the impairment or deviant development of comprehension and/or use of a spoken, written and/or other symbol system. The impairment may be manifested by any combination of the following components of language: form (phonology, morphology, syntax), content (semantics) and use/function (pragmatics).

ELIGIBILITY CRITERIA

The child demonstrates impaired or deviant comprehension and/or use of language, as determined by the results of more than one assessment procedure.

The multidisciplinary team may determine that a student has a language disorder when the student demonstrates a significant delay in one or more of the following areas: phonology, morphology, syntax, semantics or pragmatics as indicated by standard tests and/or language samples such as to interfere with the student's educational progress. A speech and language assessment must be administered by a certified speech and language pathologist.

The multidisciplinary team shall prepare a statement of eligibility and each member of the team shall sign the statement signifying his/her concurrence or dissent.

ELEMENTARY LANGUAGE PRIORITY RATING SCALE

PRIORITY I	PRIORITY II	PRIORITY III
1. Receptive and/or expressive delay of two or more years below CA.	1. Receptive and/or expressive delay of one and one-half to two years below CA.	1. Receptive and/or expressive delay of one to one-half years below C.A.*
2. Pragmatic skills that are severely limiting as measured by a TOTAL SCORE of 13 or more on the Pragmatic Skills Checklist.	2. Pragmatic skills that are moderately limiting as measured by a TOTAL SCORE of 9-12 on the Pragmatic Skills Checklist.	2. Pragmatic skills that are mildly limiting as measured by a TOTAL SCORE of 6-8 on the Pragmatic Skills Checklist.

Related factors may affect priority rating and/or number of intervention units.

# INTERVENTION UNITS		
96-120 units annually	72-90 units annually	48-60 units annually
9-30 units annually (monitor only)		

* Those kindergarten students exhibiting a language delay of one to one and one-half years during Fall testing will be re-evaluated in early January. If the language delay is still over one year they will become a priority II.

SECONDARY LANGUAGE

DEFINITION

A language deficiency is the impairment or deviant development of comprehension and/or use of a spoken, written and/or other symbol system. The impairment may be manifested by any combination of the following components of language: form (phonology, morphology, syntax), content (semantics) and use/function (pragmatics).

ELIGIBILITY CRITERIA

The student who demonstrates impaired or deviant comprehension and/or use of language, as determined by the results of more than one assessment procedure.

The multidisciplinary team may determine that a student has a language disorder when the student demonstrates a significant delay in one or more of the following areas: phonology, morphology, syntax, semantics or pragmatics as indicated by standard tests and/or language samples such as to interfere with the student's educational progress. A speech and language assessment must be administered by a certified speech and language pathologist.

The multidisciplinary team shall prepare a statement of eligibility and each member of the team shall sign the statement signifying his/her concurrence or dissent.

SECONDARY LANGUAGE PRIORITY RATING SCALE

PRIORITY I	PRIORITY II	PRIORITY III
1. Receptive and/or expressive deficit as measured by a score that falls within the 0 to 10th percentile and/or	1. Receptive and/or expressive deficit as measured by a score that falls within the 11th to 15th percentile and/or	1. Receptive and/or expressive deficit as measured by a score that falls within the 16th to 20th percentile and/or
2. Pragmatic skills that are severely limiting as measured by a TOTAL SCORE of 13 or more on the Pragmatic Skills Checklist.	2. Pragmatic skills that are moderately limiting as measured by a TOTAL SCORE of 9-12 on the Pragmatic Skills Checklist.	2. Pragmatic skills that are mildly limiting as measured by a TOTAL SCORE of 6-8 on the Pragmatic Skills Checklist.

Related factors may affect priority rating and/or number of intervention units.

# INTERVENTION UNITS		
96-120 units annually	72-90 units annually	46-60 units annually
9-30 units annually (monitor only)		

Appendix B
Item 3

PRAGMATIC (Interpersonal Communication) SKILLS CHECKLIST

The information from this checklist will be used in evaluating how the student interacts in speaking and listening situations.

Please rate the student by responding to each of the statements using the following scale:

0 = Often 1 = Sometimes 2 = Seldom

____ Uses appropriate eye contact.
Comments:

____ Uses appropriate voice loudness, pitch and intonation (not too loud or soft/not too fast or slow/uses expression).
Comments:

____ Uses appropriate speech rate and rhythm (not too fast or slow/even/not choppy).
Comments:

____ Uses clear and understandable speech (good pronunciation).
Comments:

____ Speaks in complete statements (uses good grammar/vocabulary).
Comments:

____ Initiates, maintains, completes and changes topic of conversation appropriately.
Comments:

____ Takes turns appropriately (doesn't interrupt).
Comments:

____ Asks questions and answers questions appropriately.
Comments:

____ Pays attention, shows interest and provides feedback.
Comments:

____ Uses gestures, body language and facial expressions appropriately.
Comments:

____ Observes personal space (not too close or far away).
Comments:

____ Follows directions.
Comments:

____ TOTAL SCORE SIGNATURE/TITLE _____

ARTICULATION

DEFINITION

A child with an articulation handicap has a deficiency in his ability to say sounds in conversational speech which is not consistent with his/her chronological and/or mental age.

ELIGIBILITY CRITERIA

The multidisciplinary team may determine that a student has an ARTICULATION deficiency when: 1) The student, given a test of articulation competence following developmental norms, exhibits misarticulations of one or more phonemes, and 2) The articulation deficiency interferes with communication and calls attention to itself. A speech and language assessment must be administered by a certified speech and language pathologist.

NOTE

A voiced/voiceless cognate = 1 phoneme.

ARTICULATION PRIORITY RATING SCALE

PRIORITY I	PRIORITY II	PRIORITY III
1. Speech is over 50% unintelligible and/or	1. Speech is 25-50% unintelligible and/or	1. Speech is less than 25% unintelligible and/or
2. 3 or more phonemes developmentally one year below age level are consistently affected.	2a. 2 or more phonemes developmentally one year below age level are consistently affected or b. single sound errors in 3rd grade or age 8.	2. Single sound error with one year developmental delay.

Related factors may affect priority rating and/or number of intervention units.

# INTERVENTION UNITS		
72-90 units annually	48-60 units annually	36-45 units annually
9-30 units annually (monitor only)		

Exception for students in Severely Handicapped programs:

1) If oral motor/structural problems impact phoneme production -- add 30-45 units annually.

2) If feeding is a part of oral training -- add 60 units annually.

VOICE

DEFINITION

A Voice Disorder is defined as vocal characteristics that deviate in at least one of the areas of quality, pitch, loudness or resonance.

ELIGIBILITY CRITERIA

The child demonstrates vocal characteristics that deviate in at least one of the areas of quality, pitch, loudness or resonance. The disorder is observed by the speech/language specialist and teacher and/or parent(s) over a period of at least four weeks. The priority rating level determines that need for direct instruction and is determined by the following: 1) a speech and language assessment administered by a certified or licensed speech and language specialist, 2) a physician's statement by an otolaryngologist or other physician licensed by a State Board of Medical Examiners, 3) a completed parent/teacher checklist form, and 4) a hearing screening/test.

VOICE PRIORITY RATING SCALE

PRIORITY I	PRIORITY II	PRIORITY III
1. Scores on the Wilson Scale of +3 or -3 and/or Scores on the Boone Voice Rating Severity Scale are moderate to severe on 3 or more categories.	1. Scores on the Wilson Scale of +2 or -2 and/or Scores on the Boone Voice Rating Severity Scale are moderate to mild on 3 or more categories.	1. Scores on the Wilson Scale of +1 or -1 and/or Scores on the Boone Voice Rating Severity Scale are mild/normal on 3 or more categories.
2. A physician's statement that direct instruction is appropriate and is strongly recommended for improvement to occur.	2. A physician's statement that direct instruction is appropriate and is recommended for improvement to occur.	2. A physician's statement that direct instruction is appropriate, but is optional for improvement to occur.
3. The vocal quality deviation is evident in all of the following speaking settings: a. Home setting. b. School setting. c. Recreational/ Social setting.	3. The vocal quality deviation is evident in 2 of the following speaking settings: a. Home setting. b. School setting. c. Recreational/ Social setting.	3. The vocal quality deviation is evident in 1 of the following speaking settings: a. Home setting. b. School setting. c. Recreational/ Social setting.

Related factors may affect priority rating and/or number of intervention units.

# INTERVENTION UNITS		
72-90 units annually	48-60 units annually	36-45 units annually
9-30 units annually (monitor only)		

FLUENCY

DEFINITION

A Fluency Disorder is defined as an interruption in the rhythm and/or rate of speech which is characterized by hesitations, repetitions, and/or prolongations of sounds, syllables, words or phrases.

ELIGIBILITY CRITERIA

The child demonstrates an interruption in the rhythm and/or rate of speech, which is characterized by hesitations, repetitions and/or prolongations of sounds, syllables, words, or phrases. These primary characteristics may be accompanied by associated (secondary) behaviors, such as, frustration, struggle, fear and/or avoidance of speaking situations. The disorder is observed by the speech/language specialist and teacher and/or parent(s). The priority rating level determines the need for direct instruction and is determined by the following: 1) a speech and language assessment administered by a certified or licensed speech and language specialist, 2) a completed teacher checklist form, and 3) a hearing screening/test.

FLUENCY PRIORITY RATING SCALE

PRIORITY I	PRIORITY II	PRIORITY III
1. 14 or more vocal dysfluencies per minute and	1. 7 to 13 vocal dysfluencies per minute and	1. 3 to 6 vocal dysfluencies per minute and
2. 2 or more of the following associated (secondary) behaviors are observed: a. Frustration. b. Struggle. c. Fear and/or avoidance of speaking situations and	2. 1 of the following associated (secondary) behaviors is observed: a. Frustration. b. Struggle. c. Fear and/or avoidance of speaking situations and	2. No associated (secondary) behaviors are observed and
3. Dysfluent behavior is evident in all of the following speaking settings: a. Home setting. b. School setting. c. Recreational/ Social setting. and/or	3. Dysfluent behavior is evident in 2 of the following speaking settings: a. Home setting. b. School setting. c. Recreational/ Social setting. and/or	3. Dysfluent behavior is evident in 1 of the following speaking settings: a. Home setting. b. School setting. c. Recreational/ Social setting. and/or
4. Vocal and nonvocal dysfluent behaviors affect speech rate to a severe degree: Below 50 wpm or -- Over 175 wpm.	4. Vocal and nonvocal dysfluent behaviors affect speech rate to a moderate degree: 50 to 75 wpm or -- 150 to 175 wpm.	4. Speech rate is within normal limits: Between 75 to 150 wpm.

Related factors may affect priority rating and/or number of intervention units.

# INTERVENTION UNITS		
96-120 units annually 9-30 units annually (monitor only)	72-90 units annually	45-60 units annually

RELATED FACTORS

If, in your professional judgment, the diagnostic testing scores do not accurately reflect the true priority rating and/or need for intervention units, use this form. Describe your rationale under the appropriate heading. Send a copy of this form to the SLS convenor. Circle the appropriate speech-language deficiency affected:

Articulation Language Voice Fluency

I feel the number of intervention units should be adjusted from _____ to _____.

I feel the Priority Rating should be adjusted from _____ to _____.

1 _____ Eligible in more than one Speech/Language area._____

2 _____ Language spoken at home._____

3 _____ Environmental deprivation._____

4 _____ Birth complications._____

5 _____ Hereditary factors._____

6 _____ Present school program._____

7 _____ Student motivation._____

8 _____ Parental attitude._____

9 _____ Teacher concern._____

10 _____ Health/physical concerns._____

11 _____ Emotional/social concerns._____

12 _____ Prognostic indicators._____

13 _____ Attendance history._____

14 _____ Other Agency Involvement: _____

_____ a) CSD
_____ b) Mental Health
_____ c) CCD
_____ d) E.H.S._____

15 _____ Nonverbal student using augmentative system._____

16 _____ Self-perception._____

17 _____ Other._____

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9-17-86 (12-88)

BEST COPY AVAILABLE

PORTLAND PUBLIC SCHOOLS
ARTICULATION SEVERITY RATING SCALE

(AR Eligibility Criteria: A student has an ARTICULATION disorder when the student, given a test of articulation competence following developmental norms, exhibits disordered misarticulations of one or more phonemes; and the articulation disorder interferes with communication, and calls attention to itself.

Developmental ages for phoneme mastery:
Age 3 - /m/, /p/, /w/, /h/, /n/, /b/, vowels/diphthongs
Age 4 - /d/, /t/, /g/, /k/, /f/, /j/
Age 5 - stridency should be present for sibilants
Age 6 - /l/, /y/
Age 7 - /v/, /r/, /ch/, /sh/, /ng/, /th/, /s/
Age 8 - /z/, /zh/, /x/

Parameter Assessed	Normal/Accepted Variations	Mild -- May Interfere	Moderate -- Interferes	Severe -- Limits	Profound -- Prevents
I. SKILLS AND PATTERNS* Etiologies may include: functional errors, dysarthria, dyspraxia, cleft palate, hearing loss, velopharyngeal insufficiency, etc.	Any phoneme errors noted are within the acceptable range for the developmental level and appropriate to regional/cultural variations.	One or more phoneme errors below developmental level. Phoneme Patterns include minimal shifts in place and/or manner. Examples include: substitutions involving b/v, t/o, d/	Two or more phoneme errors below developmental level. Phoneme Patterns include some substitutions and distortions. A few omissions may be present; occasional cluster reduction; major shifts in place (i.e., fronting or backing). Examples include: Sibilant distortions (lateralization and lisp-alization); liquid/glide deficiencies (r, l,).	Three or more phoneme errors below developmental level. Phoneme Patterns include some omissions and extensive substitutions; prevalent cluster reduction; unusual error patterns. Augmentative communication system may be indicated.	Multiple phoneme errors below developmental level. Phoneme Patterns include extensive omissions and some substitutions. Augmentative communication system may be indicated.
	Carryover: 90-100% during therapy sessions, 80-100% in other speech situations.	Carryover: 80-90% during therapy sessions, 50-80% in other speech situations.	Accuracy is at 50-80% during therapy, 25-50% in other speech situations.		
II. INTELLIGIBILITY of speech and/or signs	Intelligibility not affected; little or no effect on quantity or quality of communication.	Intelligibility may or may not be affected; may occasionally interfere with quantity; may be distractive to the listener.	Some effect on intelligibility; may interfere with quantity in specific settings.	Intelligible if subject is known; significantly distracting to content; frequently limits quantity.	Consistently unintelligible; isolated words may occasionally be intelligible; may rarely initiate symbolic communications.
III. RATE	Appropriate rate of speaking which does not interfere with successful communication. 140-180 words per minute is a generally accepted guideline.	Somewhat slow or fast rate of speaking which is distracting to the listener.	Extremely slow or fast rate of speaking which affects intelligibility. Etiologies may include dysprasia, dysarthria, and/or cluttering.	Extremely labored or fast rate of speaking which significantly affects intelligibility. Etiologies may include dysprasia and/or dysarthria.	Extremely labored or fast rate of speaking which significantly prevents intelligibility. Etiologies may include dysprasia and/or dysarthria.

* When phoneme errors are voiced/voiceless cognate - count as 1 phoneme, e.g., /s,z/.

8/87 Portland, Oregon

PORTLAND PUBLIC SCHOOLS
VOICE SEVERITY RATING SCALE

(AR Eligibility Criteria: A student has a VOICE disorder when the student demonstrates chronic vocal characteristics that deviate in at least one of the areas of pitch, quality, intensity and/or resonance.

Wilson and Rice Voice Profile: A diagnostic instrument which includes four descriptive scales: A) scale of laryngeal openess; B) pitch scales; C) scale of nasal resonance; and D) intensity scale.

Parameter Assessed	Normal/Accepted Variations	Mild -- May Interfere	Moderate -- Interferes	Severe -- Limits	Profound -- Prevents
I. SKILLS	Slight pitch, quality and/or resonance differences may be present. Voice variations are not noted by casual listener. May include these characteristics: Laryngeal Opening: 1; +1/-2; or +2. Resonance: 1; +1; 2. (Severity 1 through 5)	Pattern or history of abuse indicates greater potential for interference with communication. Voice variations may be noted by casual listener and may be inappropriate for age and sex. May include these characteristics: Laryngeal Opening: +2/-3; -1; or +3. Resonance: +2; -2. (Severity 4)	Voice disorder interferes with effective communication. The following may be present: Inappropriate pitch for age and sex, pitch breaks. Laryngeal Opening: +3; +2; -2; -3; or +2/-3. Resonance: +3, -3. (Severity 6 through 5)	Voice disorder restricts effective communication. Frequent pitch breaks interfere with vocal continuum. Laryngeal Opening: Includes +5 and/or -3; +2/-2; sometimes with -4 characteristics. Resonance: -2; +3; +4. Hypernasality or hyponasality interferes with intelligibility. (Severity 6 through 7)	Voice disorder prevents verbal communication. Augmentative system may be indicated.
II. ETIOLOGY -- ORGANIC PHYSICAL CONDITIONS	Vocal laryngeal pathology, if present, may include the following temporary factors: allergies, colds, abnormal tonsils and adenoids, short-term misuse.	Temporary factors may include the following: edema, allergies, colds, abnormal tonsils and adenoids, short-term misuse. Laryngeal exam confirms no chronic pathology such as nodules.	Confirmed laryngeal or other pathology which may include: nodules, polyps, ulcers, edema, partial paralysis of vocal folds, palatal insufficiency, enlarged tonsils and/or adenoids, neuromotor involvement resulting in abnormal body muscle tone/function. Abnormal vocal characteristics may include those associated with motive, hearing impairment, or dysprasia.	Confirmed laryngeal or other pathology or psychosomatic condition. Physical factors may include: unilateral or bilateral paralysis of vocal folds, laryngectomy, neuromotor involvement resulting in abnormal body muscle tone/function. Abnormal vocal characteristics may include those associated with motive, hearing impairment, or dysprasia.	Confirmed laryngeal or other pathology or psychosomatic condition. Physical factors may include: unilateral or bilateral paralysis of vocal folds, laryngectomy, neuromotor involvement resulting in abnormal body muscle tone/function. Abnormal vocal characteristics may include those associated with motive or dysprasia.

8/87 Portland, Oregon

PORTLAND PUBLIC SCHOOLS
FLUENCY SEVERITY RATING SCALE

(AR Eligibility Criteria: A student has a FLUENCY problem when the student demonstrates an interruption in the rhythm and/or rate of speech, which is characterized by hesitations, repetitions, and/or prolongations of sounds, syllables, words or phrases, and the disorder interferes with communication and calls attention to itself.

Stuttering Severity Index (SSI) - Factors include frequency of dysfluency, average duration of three longest blocks, and associated behaviors, i.e., distracting sounds, facial grimaces, head movements, movements of extremities. The total SSI rating is an interactive score of these factors. Consistency across settings should be considered.

Parameter Assessed	Normal/Accepted Variations	Mild -- May Interfere	Moderate -- Interferes	Severe -- Limits	Profound -- Prevents
I. FLUENCY	Includes normal ranges of dysfluency and normal developmental patterns.	Occasional dysfluencies under certain conditions. Dysfluency may interfere with communication. SSI Score 0-15.	Occasional dysfluency interferes with communication. SSI Score 16-34.	Dysfluency limits communication. SSI Score 34-48.	Dysfluency prevents effective communication. SSI score 41-48.
II. RATE	Appropriate rate of speaking which does not interfere with successful communication. 140-180 words per minute is a generally accepted guideline.	Somewhat slow or fast rate of speaking which is distracting to the listener.	Extremely slow or fast rate of speaking which affects intelligibility.	Not applicable	Not applicable

8/87 Portland, Oregon

PORTLAND PUBLIC SCHOOLS
SPEECH/LANGUAGE SEVERITY RATING SCALE SUMMARY

Date: _____

Name: _____

Birthdate: _____ Age _____

Classroom Placement: _____

School _____ Student I.D # _____

SLP _____

Check One: ☐ Initial ☐ Annual Review ☐ 3-Year Re-evaluation

Date of Hearing Screening: _____ Pass _____ Fail _____

Explain Failures: _____

Parameter Assessed	Accepted Variation/ Normal	Mild, May Interfere	Moderate Interferes	Severe Limits	Profound Prevents	N/A Due to Non-Speech/Prolinguistic Skills, etc.
Language Content						
Language Form						
Language Use						
Artic Skills/Phoneme Patterns					*	
Intelligibility						
Rate						
Voice Skills						
Voice Etiology						
Fluency						

* Not tested, but observed ✓ Formally assessed

Eligibility:

Is eligibility under the category of "Speech Language Impaired" affected by

Related Factors? Yes _____ No _____

If yes, please explain: _____

What is the student's handicapping condition?

Primary _____ Secondary _____

Service:

Are Speech/Language services recommended? Yes _____ No _____

Do Related Factors affect the level of service required?

Yes _____ No _____

If yes, please explain: _____

Level of Service, as Determined by Interdisciplinary Educational Team:

Priority I One or more parameters in the severe range
Priority II One or more parameters in the moderate range
Priority III Two or more parameters in the mild range

Portland, Oregon White - Sp Ed File Second White - Sp Ed Assessment Prog Goldenrod - SLP Pathologist

PORTLAND PUBLIC SCHOOLS
CONTENT AND FORM LANGUAGE SEVERITY RATING SCALE

OAR Eligibility Criteria: A student has a LANGUAGE disorder when the student demonstrates a significant delay in one or more of the following areas: phonology, morphology, syntax, semantics, or pragmatics, as indicated by standard tests and/or language samples such as to interfere with the student's educational progress.

Receptive and expressive modes should be considered assessing all parameters -- content, form, use.

Parameter Assessed	Normal/Accepted Variations	Mild -- May Interfere	Moderate -- Interferes	Severe -- Limits	Profound -- Prevents
I. CONTENT Semantics: The system that patterns the content of an utterance, intent and meanings of words and sentences.	Appropriate diagnostic tools indicate semantic development is within the acceptable range (within 1 standard deviation - above 16th percentile) relative to chronological age and appropriate to regional/cultural variations.	Appropriate diagnostic tools indicate semantic development is within 1-1 1/2 standard deviations (8th-16th percentile) relative to chronological age.	Appropriate diagnostic tools indicate semantic development is within 1 1/2-2 standard deviations (2nd-7th percentile) relative to chronological age.	Appropriate diagnostic tools indicate semantic development is within 2-3 standard deviations (below 2nd percentile) relative to chronological age.	Beyond standard rating or unable to establish a percentile or basal on a standard tool.
II. FORM Morphology/Syntax/Phonology					
Morphology: The linguistic rule system that governs the structure of words and the construction of word forms from the basic elements of meaning.	Appropriate diagnostic tests indicate form development is within the acceptable range (within 1 standard deviation - above 16th percentile) relative to chronological age and appropriate to regional/cultural variations.	Appropriate diagnostic tests indicate form development is within 1-1 1/2 standard deviations (8th-16th percentile) relative to chronological age.	Appropriate diagnostic tests indicate form development is within 1 1/2-2 standard deviations (2nd-7th percentile) relative to chronological age.	Appropriate diagnostic tests indicate form development is within 2-3 standard deviations (below 2nd percentile) relative to chronological age.	Beyond standard rating or unable to establish a percentile or basal on a standard tool.
Syntax: The linguistic rule governing the order and combination of words to form sentences, and the relationships among the the elements within a sentence.					
Phonology: See Artic culation					

continued

8/87 Portland, Oregon

PORTLAND PUBLIC SCHOOLS
LANGUAGE USE SEVERITY RATING SCALE

OAR Eligibility Criteria: A student has a LANGUAGE disorder when the student demonstrates a significant delay in one or more of the following areas: phonology, morphology, syntax, semantics, or pragmatics, as indicated by standard tests and/or language samples such as to interfere with the student's educational progress.

Receptive and expressive modes should be considered assessing all parameters -- content, form, use.

Parameter Assessed	Normal/Accepted Variations	Mild -- May Interfere	Moderate -- Interferes	Severe -- Limits	Profound -- Prevents
III. USE - Pragmatics Definition: The system that patterns the use of language in social contexts which may be expressed verbally or nonverbally.	Language sample/observations indicate pragmatic development is within the acceptable range and appropriate to regional/cultural variations.	Language sample/observations indicate pragmatic development is inappropriate in 1-4 areas, as stated below. Minimal interference with communication, pragmatic difficulties inconsistent.	Language sample/observations indicate pragmatic development is inappropriate in 5-5 areas, as stated below. Significant interference with communication, pragmatic difficulties consistent.	Language sample/observations indicate pragmatic development is inappropriate in 6-7 areas, as stated below. Significant interference with communication, pragmatic difficulties consistent.	Language sample/observations indicate pragmatic development is extremely inappropriate in all 7 areas, as stated below.

Pragmatics Checklist for Linguistic and Higher-Level Non-Speaking Students:

1. Paralinguistic behaviors: eye contact, posture, facial expression, distance between speaker and listener, gestures, volume intonation.
2. Functions -- use of language to perform a variety of communication arts: give information, describe wants/needs, by imagination. Label, practice, request action/answers, call, greet, protest, initiate/terminate social interaction, answer, give directions/locations/times, etc.
3. Conversation skill of quantity -- saying enough, not too much, or too little.
4. Conversation skill of quality -- making factually accurate statements.
5. Conversation skill of relation -- providing relevant information (to include topic control).
6. Conversation skill of manner -- being clear.
7. Interaction management -- initiation, response, pause time, interruptions/overlap, feedback to speaker, role of speaker/listener, polite forms, turntaking, repair/revision.

8/87 Portland, Oregon

PORTLAND PUBLIC SCHOOLS LANGUAGE USE SEVERITY RATING SCALE
FOR
PRELINGUISTIC AND NON-SPEAKING STUDENTS

OAR Eligibility Criteria: A student has a LANGUAGE disorder when the student demonstrates a significant delay in one or more of the following areas: phonology, morphology, syntax, semantics, or pragmatics, as indicated by standard tests and/or language samples such as to interfere with the student's educational progress.

Receptive and expressive modes should be considered assessing all parameters -- content, form, use.

Parameter Assessed	Normal/Accepted Variations	Mild -- May Interfere	Moderate -- Interferes	Severe -- Limits	Profound -- Prevents
III. USE - Pragmatics Definition: The system that patterns the use of language in social contexts which may be expressed verbally or nonverbally.	Language sample/observations indicate pragmatic development is within the acceptable range and appropriate to regional/cultural variations.	Language sample/observations indicate pragmatic development is inappropriate/inadequate for present system or level of functioning in 1-4 areas as stated below. Minimal interference with communication, pragmatic difficulties inconsistent.	Language sample/observations indicate pragmatic development is inappropriate/inadequate for present system or level of functioning in 4-6 areas, as stated below. Significant interference with communication, pragmatic difficulties consistent.	Language sample/observations indicate pragmatic development is inappropriate/inadequate for present system or level of functioning in 6-8 areas, as stated below. Significant interference with communication, pragmatic difficulties consistent.	Language sample/observations indicate pragmatic development is extremely inappropriate/inadequate for present system or level of functioning in 9-13 areas, as stated below.

Pragmatics Checklist for Prelinguistic and Non-Speaking Students:

1. Request object/action
2. Protest
3. Greet
4. Direct attention
5. Label/comment
6. Request information
7. Paralinguistic behaviors (eye contact, posture, facial expression, proximity, etc.)
8. Initiating
9. Gaining attention before communicating
10. Answering/responding
11. Turn-taking
12. Pause time
13. Interruptions/overlap

8/87

SEVERITY RATING SCALES
Umatilla ESD

ARTICULATION DISORDER is defined as the abnormal production of speech sounds.

It is a handicapping condition related to incorrect production of speech sounds which result in a discrepancy between his/her chronological and/or mental age.

Priority I	Priority II	Priority III
Dyspraxia/dysartha (10) Multiple sounds errors in which 3 or more are below age level and at least 1 or more are not stimuable in any position. (10, 8, 4) Kindergarten: Intelligibility below 50% and multiple errors in which 3 or more sound errors are below age level and are not stimuable. (9) In addition to the speech/language clinician, the articulation problem is consistently observed by the teacher, parent and/or student.	Kindergarten and older: 1. Intelligibility of 50-75% and 2 more errors below age level. (8, 2, 10) 2. Multiple sound errors in which 2 or more are below age level and at least 1 is not stimuable by the clinician. 3. Errors of (r) or (s) in the 4th grade or above. (9) In addition to the speech/language clinician, the articulation problem is consistently observed by the teacher, parent and/or student.	Intelligibility of 75-100% with 1 or more errors below age level. (8, 2, 10) One sound error below age level which is not readily stimuable by auditory stimulus. (8) In addition to the speech/language clinician, the articulation problem is consistently observed by the teacher, parent and/or student.
	-APPROPRIATE SERVICE PLACEMENT-	
The clinician will serve the child a minimum of 3 or more interventions per week or as most appropriate	The clinician will serve the child a minimum of 2 or more interventions per week or as most appropriate.	The clinician will serve the child a minimum of 1 or more interventions per week or as most appropriate. No priority III's should be enrolled in the caseload - only if cleared with the supervisor.

Jw/bw
10/8/85 Revised

400 S. E. Dorion P. O. Box 38 Pendleton, Oregon 97801 503 276-6616

CRITERION FOR DISMISSAL - ARTICULATION

The student will be dismissed if he/she meets one or more of the following:

1. Meets IEP goals and objectives.

2. Evaluation results indicate the student is no longer eligible as indicated by the priority index:
   a. The student consistently demonstrates 85-100% intelligibility in conversational speech in the therapy setting and two other settings (home, classroom).
   b. The student correctly produces all sound errors when presented with an auditory stimulus at various levels (word, sentence, reading and/or structured conversation).
   c. The student has a deviant oral structure and/or musculature that prohibits acquisition of target sound.

3. Lack of progress in six months of intervention.

4. The student receives more (-) than (+) on the related factors sheet, such as:
   a. Multiple absenses.
   b. Involvement and follow-through by parent, teacher, and/or student is poor.

5. Parent requests dismissal.

PROCESS FOR DISMISSAL (Follow district procedures)

1. Clinician reviews file and identifies appropriate criteria for dismissal.
2. If criterion for dismissal involves evaluation results, clinician sends home permission to evaluate form.
3. An MDT meeting with a minimum of teacher and clinician will be held.
4. MDT determines eligibility for dismissal.
5. Communication file is notated.
6. A change of placement meeting is held and/or the clinician sends home a change of placement form.

Student Name _____ Yes = +1 No = -1

Date _____ A positive # would indicate a shift towards enrolling.
A negative # would indicate a shift away from enrolling.

RELATED FACTORS

Answer each statement with either a yes or no. If a student has more yes answers than no answers, this may move the student to a more severe priority rating.

	Check Yes	Check No	Comments
Responses for Treatment			
1. Direct intervention is appropriate for treatment			
2. Periodic checks for consultations are needed because the student is not maintaining communication skills.			
3. Student appears to have potential for improvement but has not had enough opportunity in intervention.			
4. Parent, teacher and/or other professionals are not meeting student's needs.			
5. Through periodic consultation from the clinician, the student's needs could be met by parent, teacher and/or other professionals.			
Involvement/Concern of Parent and Teacher			
6. Parent and/or teacher expresses consistent concern about communication skills (circle who is concerned).			
7. Involvement and follow through by parent is excellent.			
8. Involvement and follow through by teacher is excellent.			
Student Factors			
9. Student is highly motivated towards remediation.			
10. Student school attendance has been consistent.			
11. Student has more than one area of communication concern (i.e. language/artic).			

* Recommendation based on the above information:

Jw/bw
1/6/86

Speech/Language Clinician Date

FLUENCY DISORDER is defined as the abnormal flow of verbal expressive, characterized by impair rate and rhythm which may be accompanied by struggle behavior.

It is a handicapping condition related to the disturbance in the normal fluency and time patterning of speech characterized by one or more of the following: audible or silent block, sound and syllable repetitions, sound prolongations, interjections, broken words and circumlocutions of words produced with an excess of tension. These primary characteristics may be accompanied by secondary behaviors and can be aggravated by the child's reactions to the dysfluencies by attempts to avoid sounds, words, situations, or audiences associated with the dysfluencies.

Priority I	Priority II	Priority III
14 or more vocal dysfluencies (prolongations, repetitions, fillers, starters) per minute.	7 to 13 vocal dysfluencies per minute.	3 to 6 vocal dysfluencies per minute.
2 or more associated behaviors consistently used (secondary behaviors).	One associated behavior.	No associated behavior.
Vocal and non-vocal dysfluent behaviors affecting speech rate to severe degree (words spoken per minute either an abnormally fast or slow rate). Words spoken per minute below 50 or over 175.	Vocal and non-vocal dysfluent behaviors affecting speech rate to a moderate degree. Words spoken per minute 50 to 75 or 150 to 175.	
Dysfluent behavior evident in 3 or more speaking contexts and/or environments which are consistent (speech samples).	Dysfluent behavior evident in less than 3 speaking contexts and/or environments but which are consistent.	Dysfluent behavior evident primarily in a single context and/or environment behavior is inconsistent.
In addition to the speech/language clinician, the dysfluent behavior is consistently observed by teacher, parent and/or student.	In addition to the speech/language clinician, the dysfluent behavior is consistently observed by teacher, parent and/or student.	In addition to the speech/language clinician, the dysfluent behavior is consistently observed by teacher, parent and/or student.
	--APPROPRIATE SERVICE PLACEMENT--	
The clinician will serve the child a minimum of 3 or more interventions per week or as most appropriate. Basic Suggestion-- If younger (6 years and below) evidences interfering dysfluent behaviors, it may be more appropriate to periodically monitor dysfluent rate as opposed to scheduling therapeutic intervention.	The clinician will serve the child a minimum of 2 or more interventions per week or as most appropriate.	The clinician will serve the child a minimum of 1 or more interventions per week or as most appropriate.

CRITERION FOR DISMISSAL - FLUENCY

The student will be dismissed if he/she meets one or more of the following criteria:

1. Meets goals and objectives of the IEP.
2. Has 80% fluent speech in conversation in two or more settings as observed by the speech clinician.
3. Student is comfortable with his/her speech.
4. No concomitant behaviors.
5. Evaluation results reveals that the student is no longer eligible to receive services (has less than 3 dysfluencies per minute and dysfluencies occur primarily in a single context/environment).
6. Lack of progress in six months.
7. Receives more (-)'s than (+)'s on the Related Factors Sheet. Some related factors include:
   a. Multiple absences
   b. Involvement and follow-through by parent, teacher and/or student is poor
   c. Parent requests dismissal.

PROCESS FOR DISMISSAL (Follow district procedures):

1. Clinician reviews file and identifies appropriate criterion for dismissal.
2. If criteria selected for dismissal involves evaluation, the clinician must obtain permission for testing.
3. MDT with a minimum of persons (clinician and teacher).
4. Team determines eligibility.
5. Communication file is notated.
6. Hold a change of placement meeting or send change of placement form.

VOICE DISORDER is defined as the absence or abonormal production of vocal quality, pitch, loudness, or resonance and/or duration.

It is a handicapping condition related to any deviation in pitch, intensity, quality or other basic verbal attribute which consistently interferes with communication, draws attention, adversely affects the speaker or the listener, or is inappropriate for the age, and/or sex of the individual. It may be organic or functional in nature and may be the result of laryngeal function or resonance disorders.

Priority I	Priority II	Priority III
Voice quality difference is evident in 3 or more speaking contexts and/or environments, or scores on the Wilson Scale +3 or -3 but which could be greater/lesser, and in addition to the speech/language clinician, the disorder is consistently observed by teacher, parent and/or student.	Voice quality difference is evident in 2 speaking contexts and/or environments, or scores on the Wilson Scale +2 or -2, and in addition to the speech/language clinician, the disorder is consistently observed by teacher, parent and/or student.	Voice quality difference is evident in 1 speaking context and/or environments, or scores on the Wilson Scale +1 or -1, and in addition to the speech/language clinician, the disorder is consistently observed by teacher, parent and/or student.
	-- APPROPRIATE SERVICE PLACEMENT --	
* The clinician will serve the child a minimum of 3 or more interventions per week or as most appropriate. * Some voice cases, such as vocal abuse may best be served on a once a week direct service basis with home and school carryover.	* The clinician will serve the child a minimum of 2 or more interventions per week or as most appropriate. * Some voice cases, such as vocal abuse, may best be served on a once a week direct service basis with home and school carryover.	* The clinician will serve the child a minimum of 1 or more interventions per week or as most appropriate. * Some voice cases, such as vocal abuse may best be served on a once a week direct service basis with home and school carryover.

CRITERION FOR DISMISSAL - VOICE

A student will be dismissed if he/she meets one or more of the following:

1. Meets IEP goals and objectives.
2. Evaluation results indicate the student is no longer eligible as indicated by the priority index:
   a. Child demonstrates appropriate use of voice in 3 or more speaking contexts and/or environments.
   b. Pass Voice Evaluation (Wilson Scale ± 1).
   c. Voice Clinic physician has made a dismissal recommendation.
3. Has shown a lack of progress in 6 months of intervention.
4. Receives more (-) then (+) on related factors sheet, such as:
   a. Multiple absences
   b. Involvement and follow-through by parent, teacher, and/or student is poor.
5. Parent requests dismissal.

PROCESS FOR DISMISSAL (Follow district procedures)

1. Clinician reviews file and identifies appropriate dismissal criterion.
2. If criterion selected for dismissal involves evaluation results, clinician must obtain permission.
3. MDT meeting is held with a minimum of the teacher and clinician.
4. MDT determines eligibility for dismissal.
5. Hold a change of placement meeting or clinician sends home a change of placement form.
6. Communication file is notated.

PRIORITY INDEX

LANGUAGE DISORDER is the impairment or deviant development of comprehension and/or use of a spoken, written, and/or other symbol system. The disorder may involve (1) the form of language (phonologic, morphologic, and syntactic systems, (2) the content of language (semantic system), and/or (3) the function of language in communication (pragmatic and semantic system) in any combination. Assessment of language should address the following areas: Form, Content, Function.

I. Form of Language

(A) Phonology: the sound system of a language and the linguistic rules that govern the sound combinations.

(B) Morphology: the linguistic rule system that governs the structure of words and the construction of word forms from the basic elements of hearing.

(C) Syntax: the linguistic rule governing the order and combination of words to form sentences, and the relationships among the elements within a sentence.

II. Content of Language

(A) Semantics: the psycholinguistic system that patterns the content of an utterance, intent and meanings of words and sentences. (including vocabulary understanding, concept formation, grammatic comprehension, but not limited to.)

III. Function of Language (Expressive and Receptive areas)

(A) Pragmatics: the sociolinguistic system that patterns the use of language in communication which may be expressed [orically, vocally, or verbally. (i.e., controlling, feeling, ritualizing, informing functions of language].

(B) Semantics is also a component of the function of language.

A child with a language handicap has a deficiency which is not consistent with his/her chronological and/or mental age in one or a combination of these areas.

* No one test in any deficit area can by itself prioritize a child for service.

* A student should not be placed in the program without other academic performance measures being utilized (MDT input).

Priority I	Priority II	Priority III
A two year or more delay in: a. Semantic skills or b. Pragmatic skills or A two or more year delay in a combination of two or more of the following areas: a. Morphology b. Syntax c. Phonology d. Auditory perception In addition to the speech/language clinician, the language disorder is consistently observed by the teacher, parent, and/or student.	A one and a half to two year delay in: a. Semantic skills or b. Pragmatic skills or A one and a half to two year delay in a combination of two or more of the following areas: a. Morphology b. Syntax c. Phonology d. Auditory perception In addition to the speech/language clinician, the language disorder is consistently observed by the teacher, parent, and/or student.	A one to one and a half year delay in a. Semantic skills or b. Pragmatic skills or A one to one and a half year delay in a combination of two or more of the following areas: a. Morphology b. Syntax c. Phonology d. Auditory perception In addition to the speech/language clinician, the language disorder is consistently observed by the teacher, parent, and/or student.
	- APPROPRIATE SERVICE PLACEMENT -	
The clinician will serve the child a minimum of 3 or more interventions per week or as most appropriate.	The clinician will serve the child a minimum of 2 or more interventions per week or as most appropriate.	The clinician will serve the child a minimum of 1 or more interventions per week or as most appropriate.

CRITERION FOR DISMISSAL - LANGUAGE

The student will be dismissed if he/she meets one or more of the following criteria:

1. Meets goals and objectives of the IKP deemed necessary by the speech-language clinician to remediate student's language deficiency.
2. Student is able to communicate effectively in a variety of settings as judged by the clinician, teacher, parent, and/or student.
3. Student's communication skills correspond with his/her cognitive abilities.
4. Evaluation results reveal that the student is no longer eligible for language services (has less than one year delay in area of concern: semantics, pragmatics, morphology, syntax, phonology, auditory perception).
5. Lack of progress in 6 months.
6. Receives more (-)'s than (+)'s on the Related Factors Sheet. Some related factors include:
   a. Multiple absences
   b. Involvement and follow-through by parent, teacher and/or student is poor
7. Parent requests dismissal.

PROCESS FOR DISMISSAL (Follow district procedures):

1. Clinician reviews file and identifies appropriate criterion for dismissal.
2. If criteria selected for dismissal involves evaluation, the clinician must obtain permission for testing.
3. MDT with a minimum of persons (clinician and teacher).
4. Team determines eligibility.
5. Communication file is notated.
6. Hold a change of placement meeting or send change of placement form.

ENTRY/EXIT CRITERIA

UMATILLA ESD SPEECH AND LANGUAGE SERVICES

LANGUAGE

Definition: LANGUAGE DISORDER is the impairment or deviant development of comprehension and/or use of a spoken, written, and/or other symbol system. The disorder may involve (1) the form of language (phonologic, morphologic, and syntactic systems), (2) the content of language (semantic system) in any combination. Assessment of language should address the following areas: Form, Content, Function.

I. Form of Language

(A) Phonology: The sound system of a language and the linguistic rules that govern the sound combinations.

(B) Morphology: The linguistic rule system that governs the structure of words and the construction of word forms from the basic elements of hearing.

(C) Syntax: The linguistic rule governing the order and combination of words to form sentences, and the relationships among the elements within a sentence.

II. Content of Language

(A) Semantics: The psycholinguistic system that patterns the content of an utterance, intent and meanings of words and sentences. (including vocabulary understanding, concept formation, grammatic comprehension, but not limited to).

III. Function of Language (Expressive and Receptive areas)

(A) Pragmatics: The sociolinguistic system that patterns the use of language in communication which may be expressed motorically, vocally, or verbally. (I.e., controlling, feeling, ritualizing, informing functions of language).

(B) Semantics is also a component of the function of language.

A child with a language handicap has a deficiency which is not consistent with his/her chronological and/or mental age in one or a combination of these areas.

412 SE Dorion PO Box 38 Pendleton, Oregon 97801 503 276-6616

Guidelines for Caseload Size for Speech-Language Services in the Schools

Committee on Language, Speech, and Hearing Services in the Schools

Developed August 1981
Final Revision July 1983

The primary problem facing speech-language pathologists working in the schools (ASHA, 1980) is the question of appropriate caseload size (Recommended Service Delivery, 1983). Speech-language pathologists are often mandated by state or local education agencies to serve extremely high numbers of communicatively impaired students. By attempting to serve such large numbers of students, progress is impeded and the quality of the services provided is questionable. Little agreement exists among state and local education agencies as to what an appropriate caseload size might be; however, speech-language pathologists are constantly being asked to defend their caseload criteria and consequent caseload size.

"Guidelines for Caseload Size for Speech-Language Services in the Schools" is an attempt by the American Speech-Language-Hearing Association (ASHA) to assist speech-language pathologists in the schools with the problem of caseload size. It is not an attempt to impose another regulation on an already inundated profession nor is it intended that the document detract from the individual speech-language pathologist's professional discretion. The recommendations are intended to give direction to speech-language pathologists and educational administrators when considering what is the most appropriate caseload size for a particular setting. Within the document, a variety of factors have been considered in recommending a maximum caseload size range. Hopefully, the document will encourage speech-language pathologists and school administrators to work cooperatively in developing realistic caseload rules and regulations that facilitate providing quality services.

In January 1981, the Executive Board of ASHA requested that the Committee on Language, Speech, and Hearing Services in the Schools (1) review available data on state education agency (SEA) mandated caseload requirements and (2) prepare guidelines regarding this issue. In August 1981, the Committee on Language, Speech, and Hearing Services in the Schools developed, "Recommended Caseload Size for Students with Communicative Disorders in the Schools." The recommendations included a description of four types of delivery programs used in the schools: (I) Consultation, (II) Itinerant, (III) Resource Room, and (IV) Self-Contained (blocks 8, 9, 10 & 11—see page 00 for blocks). Seven program characteristics are specified: (a) cases served, (b) services provided, (c) group size, (d) time per day, (e) times per week, (f) rationale, and (g) caseload size (blocks 1, 2, 3, 4, 5, 6 and 7). Reactions from speech-language pathologists were obtained via dissemination to state associations, an ASHA Annual Convention miniseminar (1982), and publication in *ASHA* and several state journals. The final revision reflects reactions to the draft. The following is a discussion of the service delivery programs and the associated recommended maximum caseload size ranges.

Program Characteristics

Cases Served (block 1)

Although it is possible to deliver services to students with a variety of disorders within any of the four service delivery programs, certain degrees of severity are more appropriately served by one program than another. In this paper, severity pertains to the communication disorder itself and not to the student's overall disability. Further, severity ratings have the same weight regardless of the communication disorder. The Committee on Language, Speech, and Hearing Services in the Schools (hereafter referred to as the Committee) purposely omitted from the recommendations any suggestions for the use of any weighted systems, formulas, or scales to determine the degree of severity. The rationale for these omissions is that: (1) many speech and language tests include a ranking of severity as a part of the test scores(s), e.g., *Arizona Articulation Proficiency Scale*, and (2) several state and local education agencies already have developed scales for determining degree of severity. Therefore, for the purpose of this paper, in "Cases Served" (block 1) the severity categories of mild, moderate, and severe are used without definition.

A number of factors influence the decision to serve a particular student. The severity of the speech, language, or hearing disorder is, of course, a prime consideration. Other factors include the influence of the communication disorder on the student's ability to function in an academic setting, the relationship of the communication disorder(s) to other handicapping conditions (such as mental retardation, learning disability, or physical or other health impairments), the stage of development of the communication disorder(s), and other factors related to the individual student.

Services Provided (block 2)

Speech-language pathologists in the schools are called upon to provide a wide variety of services which are described in this section included in the "Services Provided" section are considerations in the following areas. The speech-language pathologist is the primary person responsible for a communicatively handicapped child's program of speech and language habilitation, including: (1) development, (2) management, (3) coordination, and (4) evaluation. Another consideration is whether the service is provided directly by the speech-language pathologist, indirectly through the classroom teacher, parent(s), supportive personnel, or with the assistance of modules or self-paced programs. Finally, consideration is also given in the resource room and self-contained programs as to who is primarily responsible for a child's academic instruction: the speech-language pathologist, the classroom teacher, or both.

Group Size (block 3)

Although a range for the total caseload size (block 7) is given, a recommendation is also made for group size (i.e., the number of students served in a single session). This figure ranges from one (individual session) to a self-contained class size of 10 (or 15 with an aide). The decision to deliver services to students in a group as opposed to individually should be based on the student's communicative need and not on administrative convenience. Some students may be provided the most appropriate service in a combination of individual and group placements. Group placement for the purpose of saving time usually yields programs that lack quality services. In such cases, it would be justified to assume that the student is receiving less intense service than the amount of time stated in the individual educational plan would suggest.

Time Per Day (block 4)

This section refers to the total amount of time that the speech-language pathologist spends with an individual/group in a day. As stated previously, the time seen in service is not based on whether the student is seen individually or in a group. Time Per Day also does not include time spent in preparation, record keeping, paperwork, workshops, school duties, parent and teacher conferences, etc., but rather refers to the amount of service time spent with an individual/group. Speech-language pathologists are required to spend a great deal of time in duties other than direct service that are essential to the proper management of each case.

Times Per Week (block 5)

Times Per Week refers to the number of times each week that the speech-language pathologist has contact with an individual/group; time spent in duties other than contact with students is omitted in the direct service programs.

Rationale for Caseload Size (block 6)

A brief justification statement of the caseload size is given to support the information included in each of the other size characteristics. Refer to the discussion of an alternative service for additional rationale for caseload size.

Caseload Maximum (block 7)

For each service delivery program a maximum caseload size range recommendation is made. No minimums are recommended. Appropriateness of caseload size varies with individual circumstances. Such circumstances must be left to the discretion of the individual speech-language pathologist and others in the district responsible for establishing a plan for delivery of service. Recommendation of minimum caseload size may result in some clinicians seeing more children than can be served effectively. A maximum is recommended, however. Rather than a single number, a maximum range is recommended since varying degrees of severity may be seen within each program.

Service Delivery Programs

The four different service delivery programs described in the model, from least restrictive to most restrictive, are (1) Consultation Program (Indirect Service), (2) Itinerant Program (Intermittent Direct Service), (3) Resource Room Program (Intensive Direct Service), and (4) Self-Contained Program (Academically Integrated Direct Service). It is conceivable that a speech-language pathologist will use more than one service delivery program (e.g., serving a group of severe-profound students intensively in a resource room while working with the remainder of the caseload using an itinerant model). A speech-language pathologist must judge how to adjust his/her total caseload when using more than one program. Caseload size is not additive as more service delivery programs are used (e.g., using an itinerant and a consultation program does *not* mean a maximum caseload of 80 students). The recommendations do not allow for the extra travel time needed by speech-language pathologists who deliver services to more than one school. Travel time between schools must be an individual consideration; however, it is assumed that as the travel time increases, the number of students serviced decreases.

Consultation Program (Indirect Service) (block 8)

The consultation program is a relatively new and emerging role for the speech-language pathologist in the schools. The speech-language pathologist in this program develops a clinical management program for the communicatively handicapped student and is responsible for training and instructing others to carry out the program.

Examples of how the consultation program may be used are as varied as the students having communicative disorders. For example, a consultation program may prove beneficial in monitoring a student's communicative abilities prior to enrolling him/her into a direct service program in order to determine the degree of severity, rehabilitation potential, or most appropriate placement for service. Another application of the consultation program may be to review a student's progress after dismissal from a direct service program to insure that adequate communicative levels are maintained. Finally, the consultation program may be useful when serving students who are severely/profoundly mentally handicapped or multiply handicapped. Students who are severely mentally handicapped, for example, need intensive language stimulation in the student's natural environment. An appropriate program might be for the speech-language pathologist to evaluate the student's communicative abilities, develop a program of service, demonstrate the service program to the teachers, parents or significant others, and periodically observe/review the student's progress to insure quality services.

The consultation program is not to be considered second best or to be used when direct intervention by the speech-language pathologist is not possible, but rather selection of this program should be based on the communicative needs of the student. It should be the program of choice and not of desperation. Used appropriately, this program can be most effective. Students receiving services in this program should be counted as part of the speech-language pathologist's total caseload. Students receiving services under this program are indeed being provided with a program of habilitation in the least restrictive environment. The consultation program is suitable for all degrees of disorders from mild to severe (block 12) based on communication needs of the students. The speech-language pathologist is responsible for developing, managing, coordinating, and evaluating the program of communicative habilitation (e.g., all testing assessments, intervention strategies, methods, materials, rules for the environment, observation, demonstration service, teacher/parent training, and evaluating). However, the actual routine delivery of these services may be conducted by someone other than the speech-language pathologist (block 13). This program may be appropriate for students who are homebound, for students who have multiple handicaps and need constant communication stimulation, or with young students who can best be served in their natural environment. Speech-language pathologists who are currently using the Consultation Program are largely in one of two groups: (1) working with the teachers, speech-language pathologists and/or parents of severely/profoundly mentally handicapped students, or (2) working with teachers and parents of students in kindergarten or first grade who have mild communicative delays. In each case, however, the speech-language pathologist does not deliver services to the child directly on a regular basis (other than assessment and demonstration) but rather trains the teacher, parent, and/or aide in methods of intervention. Although the speech-language pathologist has little direct contact with the students in this model, the students are still considered as having received direct service and are included in the child count.

In the consultation program each student is receiving services on an individual basis. Each student is receiving services (tested, observed, teacher trained, program development, etc.) from one-half to four hours per day, averaging from one to five times per week (block 15). This schedule is not necessarily maintained throughout the school year. For example, a student who is using an electronic artificial voice may require intensive training, observation and teacher/parent training in the early stages of development. However, once the system is incorporated into the classroom, only periodic recheck by the speech-language pathologist may be required to insure proper maintenance. Because of the extensive and time-consuming nature of training supportive personnel and/or educators, the maximum caseload size recommended for the consultation program is 15 to 40 (block 18). The wide range in caseload size exists because a wide variety of cases/disorders may be involved and the capabilities of the parents/teachers may be even more varied. For example, one speech-language

pathologist may be providing service to five very knowledgeable kindergarten or first grade teachers regarding 30 students while another speech-language pathologist may be providing service to 15-20 professionals and family members regarding five severely multiply handicapped students; however, both are using the consultation program.

Itinerant Program (Intermittent Direct Service) (block 9)

The itinerant program, which historically has been largely used by speech-language pathologists in the schools, provides services to students with all types of disorders with varying degrees of severity from mild to severe (block 19). Attempts at selecting a different term were unsuccessful since the alternatives, while semantically appropriate, were not commonly understood or accepted. Although the term "itinerant" implies literally that the speech-language pathologist travels from school to school (which is not necessarily true with this program), "itinerant" is used even if the speech-language pathologist delivers services to only one school, because this is the term historically used and commonly accepted by speech-language pathologists and school administrators.

The speech-language pathologist is responsible for the overall evaluation, management, and coordination of the communicative habilitation program (block 20). The service includes communication testing/evaluation and teacher/parent counseling, direct intervention, generalization, and ongoing monitoring of student progress. Although the student's academic program is the responsibility of the regular classroom teacher and/or special educators, attempts are made by the speech-language pathologist to incorporate academic content into the service program. Also, educators attempt to reinforce the goals of communicative intervention into the class.

The itinerant program provides services to students who are placed in regular or special classrooms where speech-language pathology services are provided in addition to their academic program. The student is often provided service outside of the regular classroom; however, some speech-language pathologists may want to provide service to students within the regular/special classroom (physically within the classroom) if a speech-language pathologist provides service to more than one school, time for travel will reduce time for providing services to students and will reduce the maximum number of students. Speech-language pathologists must use their own discretion as to adjustments necessary in their schedule and caseload size to provide quality services.

Speech-language pathologists may provide direct services to either individuals or small groups (block 21). The lengths of the sessions are from one-half to one hour per day and services are provided from two to five times weekly (blocks 22 and 23). The maximum caseload range for the itinerant model is 25-40 (block 25). Speech-language pathologists in the schools are presently providing services to students who have more complex problems and are required to spend many hours of paperwork plus parent/teacher conferences. Speech-language pathologists no longer are segregated from the rest of the school but rather are an integral part of the school curriculum which requires more in-depth services—not 15 minutes of service twice a week in a group of ten. Also, the upper limit of 40 is only slightly lower than the national average of 43 (ASHA, 1981).

The upper limit of 40 is reduced depending on such factors as the amount of individual service required, group sizes, severity of the communicative disorders, travel time, amount of administrative paperwork required by the local education agency (LEA), etc.

Resource Room Program (Intensive Direct Service) (block 10)

The resource room program is suited for all classifications of disorders—articulation, voice, fluency, and language; however, it is primarily designed for students with severe communication disorders (block 26). While this model may be applied to all communicative disorders, it is typically used for articulation and language disorders. As with the other service delivery models, the speech-language pathologist is responsible for the overall communicative habilitation/rehabilitation program for the student including diagnosis/evaluation, parent/teacher counselling, direct intervention, generalization, and continued monitoring of the student's progress.

One key feature of the resource room program is that in addition to receiving direct service from the speech-language pathologist, the student may also be involved with self-paced modules selected and prepared by the speech-language pathologist. Further, service delivery may be divided between the speech-language pathologist and supportive personnel. While the speech-language pathologist cooperates with the regular/special educators by incorporating communication skill building activities into the student's total curriculum, the primary responsibility for academic instruction rests with the classroom teacher (block 27). A student in the resource room program may receive services individually or because of the self-paced modules, may receive services with as many as five other students per session (block 28). Because the student is out of the regular classroom for long periods of time, the speech-language pathologist should incorporate academic curriculum into the resource room program. The recommended caseload maximum range is 15-25 (block 32). If a speech-language pathologist were to provide services to groups of five one-hour blocks each day (a practice not recommended), then a maximum of 25 students could be served. To provide less service would be using a model other than the resource room. Finally, the maximum caseload range of 15-25 is consistent with most state education agency (SEA) guidelines for resource rooms for the mentally handicapped, learning disabled, etc.

Self-Contained Program (Academically Integrated Direct Service) (block 11)

The self-contained program for communicative disorders is used for those cases who are severe or have multiple communicative disorders. The program is not restricted to students who are only communicatively impaired but rather to all students whose needs are best met by a self-contained classroom for the communicatively handicapped.

The speech-language pathologist is responsible for evaluation, parent counseling, direct intervention, and continued monitoring of student progress. In addition to more traditional duties, the speech-language pathologist in this program also provides the academic instruction (block 34). Because of this unique feature, SEAs may require the speech-language pathologist to have certification in another area of education, or the class may need to be team taught in coordination with a certified classroom teacher. While a student in this program may be placed briefly with other educators during the day, she/he remains with the speech-language pathologist for most of the day (blocks 36 and 37). In this program the group size and the caseload size are the same, a maximum of 10 without an aide and a maximum of 15 with an aide (blocks 35 and 39). Because of the severe communication disorders presented by these students and the special academic considerations which are required, the caseloads for self-contained programs are the lowest of the four programs. This maximum recommendation is consistent with state education agency (SEA) guidelines for other types of handicapped self-contained classes.

Summary

The Committee on Language, Speech and Hearing Services in the Schools of the American Speech-Language-Hearing Association has addressed the issue of appropriate caseload size in the schools by preparing and disseminating documents on caseload size for speech-language services in the schools. The recommended caseload sizes are based on seven characteristics. Within each characteristic there exists a range, thereby allowing appropriate use of speech-language pathologist's professional discretion. The purpose of the document is to assist school-based speech-language pathologists and school administrators in developing their own rules and regulations governing caseload size for speech-language services.

The document described four distinct service delivery programs—consultation, itinerant, resource room, and self-contained programs. For each program, a maximum caseload range is recommended. However, no provision is made for adjusting the recommended caseload maximums when using more than one program. It is important to note that if service delivery programs are combined, caseload sizes are not additive (e.g., use of the itinerant and consultation programs does not imply a total caseload of 40-80). Other major issues that affect caseload size are required travel time between schools and the many additional responsibilities of the school-based speech-language pathologist (e.g., conferences, paperwork, school duties, etc.).

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Recommended Caseload Size for Speech-Language Services in the Schools

	8 CONSULTATION PROGRAM (Indirect Service)	9 ITINERANT PROGRAM (Intermittent Direct Service)	10 RESOURCE ROOM PROGRAM (Intensive Direct Service)	11 SELF-CONTAINED PROGRAM (Academically Integrated Direct Service
1 CASES SERVED	12 —All communicative disorders —All severities (mild to severe)	19 —All communicative disorders —All severities (mild to severe)	26 —All communicative disorders particularly language and articulation —All severities	33 —Primary handicap: communication —Severe/multiple disorders particularly language and articulation
2 SERVICES PROVIDED	13 —Program development, management, coordination —Indirect services	20 —Program development, management, coordination, evaluation —Direct services —Coordination w/educators	27 —Program development, management, coordination, evaluation —Direct service/self-study/aide —Coordination w/teachers(s) —Teacher has academic responsibilities	34 —Program development, management, coordination, evaluation —Direct services plus academic instruction
3 GROUP SIZE	14 —Individual or Group (indirect service)	21 —Individual or small group (up to 3 students/session)	28 —Individual or small group (Up to 5 students/session)	35 —Up to 10 students/speech-language pathologist —Up to 15/speech-language pathologist w/supportive personnel
4 TIME PER DAY	15 —Variable. Possible range —½ hr. (mild) to 3-4 hrs/day	22 — ½ to 1 hour/day	29 —1 to 3 hours/day	36 —Full school day
5 TIMES PER WEEK	16 —1 to 5 times/week	23 —2 to 5 times/week	30 —4 to 5 times/week	37 —Full time placement
6 RATIONALE FOR CASELOAD SIZE	17 —Time necessary by organization —Intensive needs	24 —Complex cases demand lower caseloads —Approximates national average	31 —Cases require intensive services —Consistent w/regulations	38 —Consistent w/regulations —Provides for intensive services
7 CASELOAD MAXIMUMS	18 —Up to 15-40 students	25 —Up to 25-40 students	32 —Up to 15-25 students	39 —Up to 15 students w/aide —Up to 10 students w/our aide

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NOTE: Maximums are not additive across programs and do not account for travel time.

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Appendix C

Guidelines for the employment and utilization of supportive personnel

The following revised guidelines, drafted by the Committee on Supportive Personnel, were adopted by the Legislative Council, American Speech-Language-Hearing Association (ASHA) in November, 1980. (LC 32-80) 1980 committee members were: Jerome G. Alpiner, Donald R. Bender, James C. Montague, Joanne Swagger Rosenberg, Jack M. Snyder, Catherine A. Talbot, Clare G. Maisel, Peggy S. Williams (ex officio) and Joseph W. Helmick, Chairman.

WHEREAS, the evolution of employment and utilization of supportive personnel has occurred in the field of speech-language pathology and audiology, and

WHEREAS, the American Speech-Language-Hearing Association developed guidelines in 1970 to (a) define roles and tasks of this group in the profession, (b) describe the training programs and supervision needed, and (c) evaluate the impact on the profession, and

WHEREAS, LC 5-76 charged the Executive Board to provide statements relative to differential training and employment of supportive personnel, and

WHEREAS, recent federal and state legislation has created a concern for and need to provide increased services to handicapped children in the schools, and

WHEREAS, several states have developed guidelines for the use of and are utilizing supportive personnel in audiology and speech-language pathology, therefore

RESOLVED, That the Guidelines for the Employment and Utilization of Supportive Personnel in Audiology and Speech-Language Pathology be adopted by the American Speech-Language-Hearing Association and be disseminated in the same manner as have other clinical guidelines.

Introduction

In 1967 the Executive Board of the American Speech-Language-Hearing Association (ASHA) initiated discussions relative to the need to develop guidelines regarding the use of supportive personnel in the profession. As a result of these discussions, the Committee on Supportive Personnel was created. Under the leadership of its chairman, John P. Moncur, the committee began to gather information, including data obtained from a survey administered by the committee, relative to the use of supportive personnel in the profession. Subsequent to a review of the obtained data, a second major meeting of the committee was scheduled in which selected individuals, who were conversant with supportive personnel issues, were invited to participate. The results of the committee's deliberations were the "Guidelines on the Role, Training, and Supervision of the Communication Aide," which were approved by the Legislative Council in November, 1969 and subsequently published in the *Asha* journal in February, 1970.

Along with the statement of guidelines, the Committee on Supportive Personnel submitted a list of areas of concern that would require additional study and that might lead to the development of additional or revised guidelines. Consequently, the committee was continued in an attempt to maintain some degree of currency with the evolution of supportive personnel usage in speech-language pathology and audiology.

With the advent of PL 94-142 in 1975, requiring a free appropriate public education for all handicapped children, there arose an immediate and intense concern for the acquisition of additional professional personnel to meet the increased need for services to handicapped children in the public schools. Several states saw the use of supportive personnel as a viable mechanism for obtaining needed personnel in a relatively short period of time. Several states proposed guidelines specific to the use of supportive personnel in audiology and speech-language pathology. For the most part, these guidelines incorporated the principles proposed in the guidelines adopted in 1970 by ASHA. The major substantive differences between state guidelines and those of ASHA have been procedural. In those states having licensure laws pertinent to the delivery of speech, language, and hearing services, the future dictates that these guidelines be carefully reviewed to determine the efficacy and legality of employing supportive personnel.

In addition to the impact of PL 94-142, an increased public consciousness concerning affirmative action, mainstreaming, occupational noise control and geriatric care drew attention to the roles that supportive personnel might assume in the delivery of services to the communicatively impaired.

Perhaps in response to the resurgent attention to the use of supportive personnel, the Legislative Council in 1976 provided additional charges to the Committee on Supportive Personnel (LC5-76). These charges included a request for a definition of the term "Communication Aide" and statements relative to differential training and employment of aides in audiology and speech-language pathology.

In attempting to respond to the Legislative Council, the Committee on Supportive Personnel reviewed not only the previously published guidelines and the guidelines offered by state boards and agencies, but also examined a variety of published and unpublished materials dealing with the training, utilization, and supervision of supportive personnel both within our profession and in related disciplines. (See Bibliography for a partial listing of materials reviewed by the Committee.)

As a result of our study of these materials and discussions within the committee, several issues emerged which formed the bases for these Guidelines. One of these issues was the recognition that although the audiologist and/or speech-language pathologist may delegate specific clinical tasks to supportive personnel, the legal, ethical and moral responsibility to the client for all services provided cannot be delegated, i.e., they remain the responsibility of the professional personnel.

Secondly, the committee proposed that, with the exception of responsibilities involving clinical decisions, supportive personnel could be permitted to implement a variety of clinical tasks given that sufficient training, direction and supervision were provided by the audiologist and/or speech-language pathologist responsible for those tasks. Both of these issues are specifically incorporated into statements relative to the "Role of the Speech-Language Assistant and Audiometric Assistant."

A third issue was that supportive personnel should receive training that is competency-based in character and specific to the job performance expectations held by the employer. Parallel to this issue was the fourth, the concept that just as the assistant must receive training for his/her job, the supervising audiologist and/or speech-language pathologist should also be trained in the supervision of supportive personnel. These issues are reflected in the guidelines under both the "Training and the Supervision of the Speech-Language Assistant and Audiometric Assistant."

A fifth issue developed by the committee was that the supervision of supportive personnel must be periodic, comprehensive, and documented in order to ensure that the client receives the high-quality services that he/she needs. This issue, of course, is to be found in that portion of the guidelines related to the "Supervision of the Speech-Language Assistant and Audiometric Assistant."

Finally, the committee felt that a statement of guidelines should offer general direction to both the professional and the assistant and should not attempt to specify job tasks unique to the specific goals of the agency employing the assistant, the extent of experience in clinical audiology and/or speech-language pathology accumulated by the assistant, or other factors that may vary with local needs. As a result of this perspective, the committee felt that the clinical task categories could be generalized across both audiology and speech-language pathology. Consequently, a single document is offered rather than separate statements as requested by the Legislative Council.

The committee wishes to draw attention to the need for continuous training opportunities for supportive personnel since such employment may be seen as one point of entry into the profession. While the preparation of guidelines for a sequenced training system from the level of the assistant into professional levels is beyond the scope of this committee as it is currently charged, it appears that a study of the need for and feasibility of such a system is warranted.

Definition

A variety of terms have been used to designate those individuals who have provided services in support of clinical programs in speech, language, and/or hearing disorders.* Because specific terminology is less important than a description of job performance expectations, the local agency employing supportive personnel is encouraged to adopt a term which accurately reflects the nature of the clinical duties assigned to the assistant. For purposes of these guidelines, the terms speech-language assistant and audiology assistant will be used.

The terms speech-language assistant and audiology assistant shall designate any person who, following academic and/or on-the-job training, provides clinical services as prescribed and directed by a certified audiologist and/or speech-language pathologist.** The audiologist or speech-language

*Examples of terms used include communication aide, communication assistant, speech technician, and audiometric assistant.

**Certified means one who holds the Certificate of Clinical Competence (CCC) from the American Speech-Language-Hearing Association.

pathologist shall maintain responsibility for services provided. Individuals who are enrolled in a training program or who have obtained a professional degree (e.g., B.A., B.S., A.B. degree) in speech-language pathology or audiology could be included within the definition of the terms speech-language assistant and audiology assistant. In keeping with standards for clinical certification, however, students may not use paid work experience to satisfy clinical certification requirements.

Qualification of the Speech-Language Assistant and Audiology Assistant

The following minimum qualifications should be considered in selecting individuals for employment as speech-language or audiology assistants:

1. A high school diploma or the equivalent;
2. Communication skills adequate for the tasks assigned;
3. Ability to relate to the clinical population being served.

Additional qualifications may be established according to the needs of the program and the population being served.

Training of the Speech-Language Assistant and Audiology Assistant

In keeping with local needs, a variety of traditional as well as innovative training models may be needed to prepare individuals as assistants. Whatever training model is used, emphasis should be on competency-based skill acquisition. A task analysis of the expected duties of the assistant will indicate necessary skills. Training may be provided through formal course work, workshops, observation and/or supervised practicum. Methods of training shall be determined according to the needs and resources of the work setting.

Appropriate areas for training may include any or all of the following:

1. Normal processes in speech, language, and hearing;
2. Disorders of speech, language, and hearing;
3. Behavior management skills;
4. Response discrimination skills including but not limited to the discrimination of correct/incorrect verbal responses along the dimensions of speech sound production, voice parameters, fluency, syntax and semantics;
5. Program administration skills including stimulus presentation and consequation, data collection and reporting procedures and utilization of programmed instructional materials;
6. Equipment and materials used in the assessment and/or management of speech, language, and hearing disorders;
7. Overview of professional ethics and their application to the assistant's activities.

Because training in clinical management procedures should be ongoing to take advantage of additions to the information base of the profession, it is highly recommended that the assistant be afforded continuing education opportunities primarily at the local level.

Role of the Speech-Language Assistant and Audiology Assistant

The specific role of the speech-language assistant and audiology assistant will be influenced by the particular needs of the clinical speech, language and/or hearing program and must be determined by the professional who will be responsible for training and directing the assistant. In employing the assistant, professionals must examine the implications of supervisory responsibilities on their own clinical caseloads. The uniqueness of the clinical setting may prescribe that the assistant could be used to either increase the frequency and/or intensity of clinical contact and/or to increase the total caseload.

The assistant should be assigned tasks only at the discretion of the professional and should not be assigned tasks for which he/she has not been trained. An assistant may execute specific components of the clinical speech, language, and/or hearing program if (1) it is determined by the professional that the assistant has the training and skill to accomplish the task and (2) the professional provides sufficient supervision to insure appropriate completion of all tasks assigned to the assistant. It must be emphasized that the supervising professional maintains legal and moral responsibility for all services provided by the assistant and insures that such services are in compliance with the Code of Ethics of the American Speech-Language-Hearing Association.

Following the completion of a training program, the assistant may engage only in those duties that are planned, designed and supervised by the professional. Examples of such duties are given below. These are examples only and are not intended to be of a proscriptive nature.

1. Screen speech, language, and/or hearing.
2. Conduct evaluative or management programs and procedures that are:
   a. planned and designed by the professional;
   b. included in published materials which have directions for administration and scoring and for which the assistant has received training;
3. Record, chart, graph or otherwise display data relative to client performance.
4. Maintain clinical records.
5. Report changes in client performance to the professional having responsibility for that client.
6. Prepare clinical materials, including ear molds.
7. Test hearing aids to determine if they meet published specification.
8. Participate with the professional in research projects, in-service training, public relations programs, or similar activities.

The assistant may not engage in any of the following activities:

1. Interpret obtained observations or data into diagnostic statements of clinical management strategies or procedures.
2. Determine case selection.
3. Transmit clinical information (including data or impressions relative to client performance, behavior, or progress) either verbally or in writing to anyone other than the professional.
4. Independently compose clinical reports except for progress notes to be held in the client's file.
5. Refer a client to other professionals or other agencies.
6. Use any title either verbally or in writing other than that determined by the professional.

Supervision of the Speech-Language Assistant and Audiology Assistant

Prior to employing assistants, it is essential that the professional be qualified to train and supervise assistants. The following minimum criteria should be considered. The supervising professional should:

1. Hold the CCC in speech-language pathology or audiology from the ASHA.
2. Have a minimum of one year experience in a clinical environment.
3. Have a commitment to the utilization of supportive personnel.

The maximum number of assistants supervised by one professional may vary in relation to (1) tasks assigned to the assistant, (2) time limits imposed by the supervisory guidelines given below, and (3) time required of the professional in the direct provision of clinical services. Additionally, because of the time required for training and supervision, it may be necessary to reduce the number of clients directly served by the professional in relation to the number of assistants being supervised.

One hundred percent of the assistant's clinical activities must be the responsibility of the professional. Direct on-site observations of the assistant should be completed according to the following:

1. The first 10 hours of direct client contact following training, and
2. Ten percent of all clinical sessions after the first 10 hours to include at least one in every 10 consecutive clinical sessions.

The direct observations must be documented and include information on the quality of the assistant's performance. Information obtained during direct observations may include data relative to (1) agreement (reliability) between the assistant and the supervisor on correct/incorrect judgment of target behavior; (2) accuracy in implementation of assessment and management procedures; (3) accuracy in recording data; and (4) ability to interact effectively with the client.

It is recommended that whenever areas (1) through (3) listed above fall below a 90% reliability level between the supervising professional and the assistant for three consecutive observations that the assistant be retrained in those skills and that direct observations be increased to 50% of all clinical sessions until the reliability level returns to 90% or above for three consecutive observations.

Indirect observations may include a variety of techniques such as audio- and/or videotape recordings, telephone communications, numerical data or other means agreed to by the professional and the assistant. Indirect observations must occur at least once in every five consecutive clinical sessions. In some instances, it may be necessary to change a communication assistant's duties or relieve the assistant of all duties if a high standard of proficiency cannot be attained, or if the assistant repeatedly violates these guidelines.

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